Ultra Protector® Series

Application Packet

Ultra Protector Series Whole Life insurance offers you and your family these valuable benefits:

- ✓ Guaranteed level premiums
- ✓ Every client can qualify for coverage[1]
- ✓ Pipe and cigar smokers may qualify for Ultra Protector I
- ✓ Simple application process – no medical exams[2]
- ✓ Coverage cannot be canceled because of age or health

Ultra Protector Series offers three products for different situations:	How do I qualify?
Ultra Protector I - Full Death Benefit › Accelerated Benefit Payment Rider (Rider Series 2146), included at no additional cost › Optional Accidental Death Benefit Rider available (Rider Series 2175) › Optional Children's Term Rider available (Rider Series 2147)	All health questions on the application are answered "no" (parts 1 and 2).[3]
Ultra Protector II - Full Death Benefit › Accelerated Benefit Payment Rider (Rider Series 2146), included at no additional cost › Optional Accidental Death Benefit Rider available (Rider Series 2175) › Optional Children's Term Rider available (Rider Series 2147)	All health questions in part 1 are answered "no", one or more questions in part 2 are answered "yes."[3]
Ultra Protector III - 3-Year Death Graded Death Benefit; Guaranteed Issue › Accidental Death Benefit Provision included at no additional cost	No health questions are answered on the application OR any "yes" answers are reported in part 1 of the application.

Americo Financial Life and Annuity Insurance Company is authorized to conduct business in the District of Columbia and in all states except NY.

1Subject to issue age limits and state availability. 2Issuance of policy may depend upon answers to medical questions. 3MIB and height and weight must be within guidelines to issue Ultra Protector I and II. Some riders are optional and available for an additional cost. Ultra Protector Series (Policy Series 312/313), Accelerated Benefit Payment Rider (Rider Series 2146), Children's Term Rider (Rider Series 2147), and Accidental Death Benefit Rider (Series 2175) are underwritten by Americo Financial Life and Annuity Insurance Company, Kansas City, MO. Certain restrictions and variations apply. Consult policy and riders for all limitations and exclusions. For exact terms and conditions, please refer to the contract.

AMERICO®

Application/Document

Transmittal Form

AFSFAX2002 (01/16)

Your application(s)/document(s) can be submitted through the following methods:

- Toll Free Fax Numbers:
  800.395.9261, 800.395.9238, or 877.388.3448
- E-mail: submit@americo.com
- Web Upload: www.americo.com

If this form is completed and used as your cover sheet for a new policy application, you will receive a confirmation message with the policy number by fax or e-mail. Confirmation will be delivered the same day if the application is received by 5 p.m. CST/CDT or the next business day if received after 5 p.m. CST/CDT. If you have any questions or need assistance with the submission process, please feel free to call the Agent Contact Center at 800.231.0801.

When submitting applications via web upload or e-mail, please note that the maximum file size we can accept is 25MB. In addition, we accept the following file types: PDF, TIFF, or JPEG.

PLEASE PRINT LEGIBLY

Agent / Agency Name:	Agent / Agency Phone Number:	Total No. of Pages Sent:
Fax Number and/or Email Address to Send Confirmation to:	Agent Code:	

Policy Number (if Applicable)	Applicant / Insured Name	Notes

Application for
Individual Life Insurance AGA5143

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

A PROPOSED INSURED INFORMATION

1. Name *(Last, First, Middle Initial)*	2. Date of Birth *(MM/DD/YYYY)*	3. Age	4. Gender ☐ Male ☐ Female

5. a. Mailing Address

b. Street Address *(If different than Mailing Address.)*

c. Years at current address: _____ If less than five (5) years, prior address is needed.

6. Phone Number ☐Home ☐Cell ☐Work

7. Email Address	8. SSN or Taxpayer ID	9. Place of Birth *(City, State, Country)*

10. Is the Proposed Insured also the Owner? *(If Yes, skip Section B)* ☐ Yes ☐ No

B OWNER INFORMATION

1. Name *(Last, First, Middle Initial)*	2. Relationship to Proposed Insured	3. SSN or Taxpayer ID

4. a. Mailing Address

b. Street Address *(If different than Mailing Address.)*

c. Email Address

C BENEFICIARY INFORMATION *(Include percentage shares. If shares are not given, they will be equal.)*

If not specified, all beneficiaries will be Primary.	Name	Date of Birth *(MM/DD/YYYY)*	Phone Number	Relationship	% of Share *(Must total 100%)*
Primary					
☐Primary ☐Contingent					
☐Primary ☐Contingent					
☐Primary ☐Contingent					

D PRODUCT INFORMATION

1. **Base Policy:** ☐ Ultra Protector I ☐ Ultra Protector II ☐ Ultra Protector III

☐ Check here if you are willing to accept any Ultra Protector product for which you qualify based on this application. The insurance for which you qualify may have a graded death benefit for the first three (3) years, a face amount less than any indicated on this application, and riders may not be available. All premiums will be applied toward the insurance for which you qualify.

2. **Riders** *(only available with Ultra Protector I and Ultra Protector II)*

☐ Accidental Death Benefit Rider

☐ Children's Term Rider: ..... $_____

If elected, complete the Children's Term Rider health information question below.

3. Face Amount	4. Premium Mode	5. Modal Premium	6. ☐ Check here to select Automatic Premium Loan.
☐ Solve for Face Amount ☐ Face Amount: $_____	☐ Monthly Bank Draft ☐ Annually	$_____	

E CHILDREN'S TERM RIDER HEALTH INFORMATION *(Complete only if the Children's Term rider is selected)*

1. List below any Eligible Child proposed for coverage. **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 on the federal tax return of, and resides with, the Proposed Insured.

Full Name of Eligible Child Proposed for Coverage	Date of Birth	Sex	Height	Weight
		☐ M ☐ F		
		☐ M ☐ F		

2. In the past seven (7) years, has any Eligible Child proposed for coverage been diagnosed or treated by a member of the medical profession for: birth defects, Down's syndrome, or blood disorders; cancer, convulsions, or seizures; diabetes or digestive disorder; emotional or psychiatric disorder; nervous system disorder; alcohol or drug abuse; heart disorder, kidney or liver disorder, lung or respiratory disorder; AIDS or AIDS-Related Complex; or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? ..... ☐ Yes ☐ No

3. Has any Eligible Child proposed for coverage been diagnosed or treated by a member of the medical profession for any disease or disorder not mentioned above? *(If **YES**, provide details in table below.)* ..... ☐ Yes ☐ No

Name of Eligible Child	Diagnosis or Reason Treated	Treatment Date(s)	Name/Address/Phone Number of Doctor/Hospital

F REPLACEMENT INFORMATION

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? ☐ Yes ☐ No

If **Yes**, provide information in the table below and answer question 2. If **No**, skip question 2, and proceed to the next applicable section.

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

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

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

G PROPOSED INSURED HEALTH INFORMATION

☐ The Proposed Insured elects Ultra Protector III and to not answer health questions.

Proposed Insured's Height:	Proposed Insured's Weight:

Part 1	**Yes**	**No**
1. Is the Proposed Insured currently hospitalized, bedridden confined to a nursing facility, receiving hospice or home health care?	☐	☐
2. Is the Proposed Insured now or within the last six months:		
a. Using oxygen to assist in breathing?	☐	☐
b. Confined to a wheelchair or using a walker for a chronic illness?	☐	☐
3. Within the last twelve (12) months, has the Proposed Insured been advised to have tests or surgery, which have not been completed, or waiting for a medical diagnosis or results of medical tests or procedures which have not been received?	☐	☐
4. Is the Proposed Insured waiting for or have they received an organ transplant?	☐	☐
5. Is the Proposed Insured paralyzed or has the Proposed Insured been diagnosed with a terminal illness?	☐	☐
6. Has the Proposed Insured:		
a. Had, been told they have, been treated for, or been prescribed medication for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's Disease)?	☐	☐
b. Been diagnosed as having, been treated by a medical professional for, or tested positive for: AIDS, AIDS-Related Complex, or HIV?	☐	☐
7. In the past three (3) years, has the Proposed Insured been told they have, or been treated by surgery, chemotherapy, radiation, been prescribed medication for any internal cancer or malignant melanoma (not basal cell skin cancer)?	☐	☐
8. In the past twelve (12) months, has the Proposed Insured had, been told they have, been treated for, been prescribed medication or had surgery for: heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder; cardiac arrhythmia (including atrial fibrillation or flutter and ventricular fibrillation or flutter), heart attack, or angina (chest pain)?	☐	☐
9. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication or had surgery for congestive heart failure, cardiomyopathy, stroke, circulation or blood clot problems in the legs or to the heart or brain, systemic lupus, chronic kidney disease, or kidney failure?	☐	☐
10. In the past two (2) years has the Proposed Insured:		
a. Had, been told they have, been treated for, or been prescribed medication for drug or alcohol abuse/dependency or addiction?	☐	☐
b. Been asked to discontinue use or reduce intake of drugs or alcohol?	☐	☐
11. Do you take medication for diabetes, and if so, do you have a history of any heart disease (not including hypertension) kidney disease, stroke, TIA, or any circulatory disease affecting the heart or blood vessels?	☐	☐

Part 2		
1. Has the Proposed Insured smoked cigarettes within the last twelve (12) months?	☐	☐
2. Within the past two (2) years, has the Proposed Insured ever been told they have, been treated for, or been prescribed medication for: Parkinson's disease, cirrhosis of the liver, chronic hepatitis, or other liver diseases or disorders?	☐	☐
3. In the past two (2) years, has the Proposed Insured experienced complications of diabetes including: retinopathy (eye disease), nephropathy (kidney disease), neuropathy, amputation, insulin shock, or diabetic coma?	☐	☐
4. In the past two (2) years, has the Proposed Insured had, or been told they have, been treated for, or been prescribed medication for heart bypass, angioplasty (balloon procedure), stent placement, heart valve disorder, heart attack, angina (chest pain), or coronary disease?	☐	☐
5. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for emphysema, or any other chronic respiratory or lung problem excluding allergies or asthma?	☐	☐

Provide details on any "YES" answers in Section H. Eligibility for a level death benefit policy (Ultra Protector I or Ultra Protector II), is based on answers to the Health Questions and additional underwriting criteria.

H HEALTH QUESTION DETAILS/REMARKS *(Attach a separate sheet if needed. Additional sheet must be signed and dated by Proposed Insured/Owner to avoid amendments.)*

I AUTHORIZATION AND ACKNOWLEDGMENT

Information regarding Your insurability will be treated as confidential. Americo Financial Life and Annuity Insurance Company (Americo) is a member of MIB, Inc. (MIB). Americo, or its reinsurers, may make a brief report to MIB, which operates an information exchange on behalf of its members. If You apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may supply such company with the information in its file. Americo or its reinsurers may also release information to other insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. You may request to see the information kept in Your MIB file. You may also contact MIB and seek a correction for any errors in Your file.

Your authorization permits any insurance or reinsurance company, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or MIB, Inc. that has any information about You, or anyone listed in this application that are proposed to be insured, to give Americo, its reinsurers or its authorized representatives, information about other insurance coverage, age, general character, habits, medical care or advice about any physical or mental condition, including information about drugs and alcoholism, required by Americo to determine insurability and/or claims eligibility, for the duration of the claim. Health information obtained will not be re-disclosed without Your authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

You, or Your authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

By providing Your Authorization and Acknowledgement, You:

- ACKNOWLEDGE any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner.
- AUTHORIZE Americo to act on electronic and/or telephonic information from all parties specified in this application. This authorization may be revoked by sending written notice to Americo at its administrative office address. The absence of this authorization constitutes a rejection of this authorization.

You furthermore agree to the following:

- The answers and statements in the application for insurance are the basis for any policy issued by Americo and no information will be considered to have been given to Americo unless it is stated in the application.
- Your sales representative does not have Americo's authorization to waive the answer to any question in this application, nor decide on the insurability, nor waive any of the company's underwriting requirements, nor change any contract.
- All answers and statements in this application for insurance, as they pertain to You, are true and complete to the best of Your knowledge and belief.

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

_____	_____	_____
Signature of Proposed Insured *(required)*	Signature of Owner *(if different than Proposed Insured)*	Signature of Witnessing Agent *(required)*

AGENT'S REPORT

Proposed Insured's Name:_____

1. Is the Agent related to the Proposed Insured(s)? ☐ Yes ☐ No If **Yes**, provide relationship: _____

Provide details of all No answers in the Agent Comments/Remarks section.

	Yes	No
2. How long has the Agent known the Proposed Insured(s)? _____		
3. At the time this application was taken, were all of the Proposed Insured(s) present and did you witness their signatures?	☐	☐
4. Did the Proposed Insured(s) directly respond to each application question?	☐	☐
5. Was a government-issued picture I.D. requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor *(if different than the Proposed Insured)*?	☐	☐

Provide details of all Yes answers in the Agent Comments/Remarks section.

6. Did the applicant approach you to purchase insurance? *(If **Yes**, list their stated need for the insurance in the Agent Comments/Remarks section.)*	☐	☐
7. Does the applicant have any existing life insurance or annuities on the life of any Proposed Insured?	☐	☐
8. Will the life insurance applied for replace, or otherwise reduce in value, any life insurance or annuity now in force?	☐	☐

Complete replacement form(s) in accordance with applicable state replacement regulations. Provide copies of replacement form(s) to the Owner and the Company. Leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the Agent Comments/Remarks section above.

Agent Signature	Print Agent Name	Agent Phone Number	Agent Email Address	Agent #	%

BANK DRAFT AUTHORIZATION

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. **This authorization will remain in effect until revoked by me or the Company. Notifications should be sent to PO BOX 410288, Kansas City, MO 64141-0288, Attention Customer Service. Our toll-free number is 800.231.0801.** I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever.

Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated and that my insurance policy may lapse. I further understand that Americo requires a 5 business day advance notice to set up, change, or discontinue my bank draft information and should any draft not be honored for the reason of "insufficient funds", a second attempt to draft may occur within 5 business days from the returned draft date.

Requested Draft Date: _____-_____ *(Must be within 10 days of the Due Date and cannot be on the 29th, 30th, or 31st of the month. It may take up to 4 business days from the day we initiate the draft for your bank to process this transaction.)*
Month Day

ACCOUNT INFORMATION

(check one)

☐ Checking Account *(include voided check or enter account information below)*

☐ Savings Account *(include deposit slip or enter account information below)*

☐ Check with Application *(Use the deposit & routing number from the enclosed check in lieu of a voided check.)*

☐ Check here if the account selected above is a business account.

X _____ _____
Payor's Signature *(as it appears on bank records)* Date

PAYOR INFORMATION *(Complete if Payor is different than Proposed Insured & Owner.)*

Name	Relationship to Proposed Insured
SSN or Taxpayer ID	Proposed Insured's Name

Address (*If address is a PO BOX, a street address is also required.)*

Years at current address: _____ If less than 5 years, prior address required.

Attach Voided Check/Deposit Slip Here

or

Complete and sign below only when voided check or deposit slip is not available.

Routing Number														
Account Number														

Agent's Certification

I do hereby attest that I personally verified this information. I understand that any misrepresentation or falsification on my part will rescind my privilege to use this form and may lead to immediate termination of my appointment with the Company.

X _____ _____
Agent's Signature (REQUIRED) **Agent's Number**

IMPORTANT NOTE: sign and submit this Disclosure ONLY when applying for Ultra Protector I or Ultra Protector II.

Disclosure Statement for
Accelerated Benefit Payment Rider
Rider Series 2146

AMERICO

AAA8386

GENERAL DESCRIPTION OF THE ACCELERATED BENEFIT

The Accelerated Benefit Payment Rider allows the Owner of the Policy to which the Rider is attached to receive an accelerated benefit following a Qualifying Event. A Qualifying Event is defined as a non-correctable medical condition of the Insured that, with reasonable medical certainty, will result in the death of the Insured in 12 months or less. The Company must receive a physician's written statement certifying the medical condition and the Insured's life expectancy.

The Owner may make only one request for an accelerated benefit payment. The Owner may request an accelerated payment of up to 50% of the death benefit amount after deducting all outstanding Policy loans. The minimum accelerated benefit the Company will pay is $1,000 and the maximum benefit is $15,000. The accelerated benefit will be paid only as a lump sum.

Request for an accelerated benefit payment must be in writing and the Company must receive the request while the Policy is in force (other than as extended term or paid-up insurance, if available). The Company must receive written approval by any irrevocable beneficiary under the Policy and a full release of any assignment of the Policy as collateral.

TAX CONSEQUENCES OF RECEIVING AN ACCELERATED BENEFIT PAYMENT

Depending on a number of factors, an accelerated benefit payment may be considered taxable income. The Owner should seek assistance from a qualified tax advisor before requesting an accelerated benefit.

COSTS OF THE ACCELERATED BENEFIT PAYMENT

There is no premium for the Rider. However, the Company will add an administrative fee not exceeding $250 to the accelerated benefit amount at the time of payment. The Company will charge interest on the accelerated benefit payment. Interest will accrue at the policy loan interest rate stated in the Policy on the portion of the benefit amount equal to the cash value. For the portion of the benefit amount that exceeds this amount, interest will accrue at a rate no more than the greater of: (a) the current yield on a 90-day treasury bill; or (b) the current maximum adjustable policy loan interest rate allowed by law.

EFFECT OF ACCELERATED BENEFIT PAYMENT

The accelerated benefit payment, the administrative fee and any accrued interest will be a lien against the Policy. The total amount of the lien and all Policy loans outstanding will reduce the amount otherwise available under the Policy's: (1) death benefit and (2) cash value.

The Rider provides that the Company will waive all premiums under the Policy and riders, if any, for up to 12 months immediately following the payment of an accelerated benefit. If the Insured is living following the twelfth month, the waiver provided by the Rider will no longer apply and premiums will be due.

Except as stated in the waiver provision of the Rider, Policy and rider premiums will remain payable and will not be reduced or eliminated as a result of an accelerated benefit payment. Any accidental death benefit provision of the Policy or any other rider attached to it will not be affected by the payment of an accelerated benefit payment.

ACKNOWLEDGMENT

I, the undersigned Insured (and Policy Owner, if other than the Insured), acknowledge that I have read and received this Disclosure Statement for Accelerated Benefit Payment Rider at the time of application for the Rider.

Proposed Insured's Signature	Date*	Owner's Signature (if other than Proposed Insured)	Date*	Agent or Broker's Signature	Date*

***Important Note:** signed date must be the same as the signed date on the application.

Premium
Conditional Receipt

THIS IS A CONDITIONAL RECEIPT — PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED BY YOUR FIRST PAYMENT UNLESS ALL TERMS IN PARAGRAPH "FIRST" ARE MET EXACTLY AND IN FULL! NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS.

Received from _____ on (Month/Day/Year) _____ $_____ by check, preauthorized order for withdrawal, or salary deduction plan. This payment is the amount of the first full modal premium for the policy applied for in the application for life insurance to Americo Financial Life and Annuity Insurance Company having the same number and date as this Conditional Receipt. This payment is made and accepted under the terms of this Conditional Receipt. This Conditional Receipt cannot be transferred. ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY. DO NOT MAKE ANY CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. If your check or draft is not honored when first presented for payment, this Conditional Receipt will not be valid.

FIRST: TERMS ALLOWING INSURANCE TO BECOME EFFECTIVE BEFORE POLICY DELIVERY: If ALL of the following terms are met exactly and in full, insurance under the terms of the policy applied for, if then being sold by the Company, will become effective on the Effective Date subject to the limitations in Paragraph "SECOND": (1) All representations made in the application must be true and complete in all material respects; (2) all medical examinations, X-rays, tests, physician's statements and any other underwriting requirements of the Company must be completed and received not later than 60 days from the date the application is signed; (3) all persons proposed for insurance in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (A) on the Plan applied for (B) in the amount and (C) in a premium class not less favorable than the premium class applied for and with no ratings; and (4) the amount shown above must be equal to at least the first full modal premium for insurance.

IF ANY PROPOSED INSURED DIES DURING THE PROCESSING OF THIS APPLICATION AND BEFORE ALL OF THE FOREGOING TERMS HAVE BEEN MET, NO INSURANCE COVERAGE WILL EXIST, AND THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUMS RECEIVED, IF ANY.

IF ALL OF THE TERMS ABOVE ARE NOT MET EXACTLY AND IN FULL, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE AMOUNT FOR WHICH THIS CONDITIONAL RECEIPT WAS GIVEN. "Effective Date" means the latest of: (1) the date the application is signed; (2) the date all required information is completed and received by the Company; and (3) the date of issue.

SECOND: LIMITS OF LIABILITY — MAXIMUM AMOUNT OF INSURANCE AND PERIOD OF TIME WHICH INSURANCE CAN BECOME EFFECTIVE BEFORE POLICY DELIVERY. The Company's liability for insurance under this Conditional Receipt plus all insurance which is in force or is pending in the Company on any Proposed Insured can never exceed $250,000 of life insurance including (a) Accidental Death Benefits, and (b) any coverage in force. The time for which the Company can be liable under this Conditional Receipt can never exceed a period of 60 days from the date this Receipt was signed.

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

X _____ Signature of Licensed Agent

X _____ Signature of Applicant

If the application is not approved and accepted within 60 days from the date it was signed, the Company shall have no liability except for the return of this payment on surrender of this Receipt.

AAA8404

Important
Consumer Notices

INFORMATION PRACTICES NOTICE

THIS NOTIFICATION MUST BE DELIVERED TO THE PROPOSED INSURED WHEN THE APPLICATION IS COMPLETED.

Thank you for your application. This notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We rely primarily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies. In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have a right of access and correction with respect to this information. You have the right to receive, in writing, the specific reason for an adverse underwriting decision. If you wish a more detailed explanation of our information practices, please write us at: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting/New Business Department. Any requests to correct, amend or alter will be responded to within 30 days. Information that is corrected will be provided to any person who is designated by the requesting party and who may have received the information in the prior two years (within a seven year timeframe). Any statement of disagreement made by a requesting party will be filed and made available to those reviewing it in the future.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. formerly known as Medical Information Bureau, a nonprofit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORTS

We may make or obtain an investigative consumer report, which may contain information secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report may contain information as to your character, general reputation, personal characteristics and mode of living. The consumer reporting agency may keep a copy of the report and may disclose its contents to others for whom it performs such services. On receipt of a request from you, we will tell you if a report has been requested and we will provide you with the name, address, and telephone number of the consumer reporting agency. You may request to be personally interviewed and, when the report is completed, you have a right to inspect and receive a copy of it from the consumer reporting agency. Please send your request to: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting Department.