Individual Life Insurance
Policy Administration Application
Reinstatement • In-Force Policy Change XFL5150

IMPORTANT NOTE: This form must be completed by the Owner, and the Insured, if different, must answer all health or personal history questions, as applicable.

☐ **AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY** ☐ **UNITED FIDELITY LIFE INSURANCE COMPANY**

☐ **GREAT SOUTHERN LIFE INSURANCE COMPANY** ☐ **INVESTORS LIFE INSURANCE COMPANY OF NORTH AMERICA**

☐ **NATIONAL FARMERS UNION LIFE INSURANCE COMPANY** ☐ **THE OHIO STATE LIFE INSURANCE COMPANY**

Members of the Americo Life, Inc. family of insurance companies. Administrative Office: PO BOX 410288, Kansas City, MO 64141-0288

Please check the Company that issued or assumed Your policy. *Some transactions may not be available for all policies for every company listed above. Contact Policy Holder Services toll free at 1.800.231.0801 or Your agent if You have any questions regarding available transactions. In this application, "Company" refers to the insurance company whose name is checked above. The insurance company checked is solely responsible for the obligation and payment of benefits under any policy it may issue; no other company shown is responsible for such obligations or payments.*

This application is a request for: (check one) ☐ Policy Change ☐ Reinstatement

SECTION A. *(Complete Section A for all requests)*

1. PRIMARY INSURED INFORMATION

a. Policy Number	b. Plan of Insurance	c. Face Amount: $_____	d. Premium: $_____ Mode: _____ If change to premium mode is requested, check here: ☐
e. Primary Insured's Name *(Last, First, MI)*			f. ☐ Single ☐ Married g. ☐ Male ☐ Female
h. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*			
i. How long at current address? _____ *(If less than 5 years at current address, prior address is required.)*			
j. Primary Phone ☐ home ☐ work ☐ mobile	k. Alternate Phone ☐ home ☐ work ☐ mobile	l. Email Address	
m. Social Security Number	n. Date of Birth *(MM/DD/YYYY)*	o. Age	p. Place of Birth *(City, State, Country)*
q. Is the Insured currently employed? ☐ Yes ☐ No	r. Occupation for last five (5) years:	s. Annual Salary: $_____	
t. Employer	u. Length of Employment	v. Employer's Phone Number	
w. Employer's Address *(Include City, State, and ZIP.)*			
x. Provide description of job duties:			

y. Does the Insured have any life insurance now in force? ☐ Yes ☐ No If Yes, provide information in the table below:

Insurance Company	Policy Number	Effective Date	Amount of Life Insurance	Amount of Accidental Death Insurance

2. OWNER INFORMATION *(Complete only if different from the Insured. Must match current Owner information on file)*

a. Owner's Name *(Last, First, MI)*	b. Relationship to Primary Insured	c. SSN or Taxpayer ID
d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*		
e. How long at current address? _____ *(If less than 5 years at current address, prior address is required.)*		
f. Primary Phone ☐ home ☐ work ☐ mobile	g. Alternate Phone ☐ home ☐ work ☐ mobile	h. Email Address
i. Date of Birth *(MM/DD/YYYY)*	j. Place of Birth *(City, State, Country)*	

3. PAYOR INFORMATION *(Complete only if different from the Insured and Owner.)* **If change to Payor, please check here:** ☐
Submit a new bank authorization form, if applicable.

a. Payor's Name *(Last, First, MI)*	b. Relationship to Insured	c. SSN or Taxpayer ID

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

e. How long at current address? _____ *(If less than 5 years at current address, prior address is required.)*

f. Primary Phone ☐ home ☐ work ☐ mobile	g. Alternate Phone ☐ home ☐ work ☐ mobile	h. Email Address

SECTION B. POLICY CHANGE *(Complete only if requesting an **In force Policy Change**)*

(1) Change Face Amount from: $_____ to $_____
(2) Change Death Benefit Option to: ☐ A (level) ☐ B (increasing)
(3) Non-nicotine/non-smoker discount? ☐ Yes ☐ No Date discontinued nicotine use or smoking:_____
(4) Add Rider(s)/Amount: _____/$_____, _____/$_____, _____/$_____, _____/$_____
(5) Delete Rider(s)/Amount: _____/$_____, _____/$_____, _____/$_____, _____/$_____

If applying for an **increase in coverage or benefits**, complete **Section E. Personal History** and **Section F. Medical History.**

If applying for an **Additional Insured, Child, or Spouse rider**, also complete **Section D. Additional Insured.**

Unless an immediate increase in premium is required to make the requested change, no change in billable premium will be made without Your consent.

SECTION C. REINSTATEMENT *(Complete only if requesting a **Reinstatement**)*

(1) Change Face Amount from: $_____ to $_____
(2) Change Death Benefit Option to: ☐ A (level) ☐ B (increasing)
(3) Non-nicotine/non-smoker discount? ☐ Yes ☐ No Date discontinued nicotine use or smoking:_____
(4) Add Rider(s)/Amount: _____/$_____, _____/$_____, _____/$_____, _____/$_____
(5) Delete Rider(s)/Amount: _____/$_____, _____/$_____, _____/$_____, _____/$_____

Complete section E. Personal History and Section F. Medical History, unless Your request for reinstatement is for a policy issued on a guaranteed issue basis.

Complete Section D. Additional Insured if You are reinstating coverage for an Additional Insured, Child, or Spouse rider.

SECTION D. ADDITIONAL INSURED *(Complete only if a rider is requested for an Additional Insured, Child or Spouse.)*

Additional Insured's Name *(Last, First, MI)*	Date of Birth *(MM/DD/YYYY)*	State of Birth	Sex	Social Security Number	Occupation and job duties	Relationship to Primary Insured
			☐M ☐F			
			☐M ☐F			
			☐M ☐F			
			☐M ☐F			
			☐M ☐F			

SECTION E. PERSONAL HISTORY *(Provide details of all "Yes" answers in the Personal History Details section below.)*

		Primary Insured Yes	Primary Insured No	Additional Insured Yes	Additional Insured No
1.	Within the past 2 years, have You: a. made any flights as a pilot, student pilot, or member of a flight crew?	☐	☐	☐	☐
	b. engaged in the following hazardous sports: bungee or base jumping, aeronautics (such as parachuting, hang gliding; skydiving, ultralight, soaring, or ballooning); competitive skiing/snowboarding (such as heli-skiing big air, slopestyle, or ski jumping); diving activities (such as scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing performance testing or student driving (such as automobiles, truck, cycle, boat, motocross, or drag racers); rock or mountain climbing, spelunking; rodeo riding, or inline skating (vert, street, or speed)?	☐	☐	☐	☐

SECTION E. PERSONAL HISTORY *(Provide details of all "Yes" answers in the Personal History Details section below.)*

		Primary Insured Yes	Primary Insured No	Additional Insured Yes	Additional Insured No
2.	Within the past 7 years, have You been convicted of, pleaded guilty to, or entered a plea of no contest to any felony?	☐	☐	☐	☐
3.	Within the past 5 years, have You:				
	a. had a driver's license suspended or revoked, or are You currently under license suspension or revocation?	☐	☐	☐	☐
	b. been convicted of reckless driving or driving under the influence of alcohol or drugs?	☐	☐	☐	☐
4.	Have You been convicted or pled guilty to:				
	a. more than two moving violations in the past 5 years; or,	☐	☐	☐	☐
	b. more than 3 violations in the past 3 years?	☐	☐	☐	☐

5. List any driver's license number(s) used in the past 5 years for any Primary Insured/Additional Insured:

Name on Driver's License	Driver's License Number	State Issued

PERSONAL HISTORY DETAILS

Question #	Date(s)	Details	Primary Insured	Additional Insured
			☐	☐
			☐	☐
			☐	☐
			☐	☐

SECTION F. MEDICAL HISTORY *(Provide details of all "Yes" answers in the Medical History Details section below.)*

1. a.	Primary Insured's Height	' "	b.	Primary Insured's Weight	lb.
2. a.	Additional Insured's Height	' "	b.	Additional Insured's Weight	lb.

		Primary Insured Yes	Primary Insured No	Additional Insured Yes	Additional Insured No
3.	Within the past 7 years, has any Proposed Insured been diagnosed, treated, tested positive for, or been given advice by a licensed member of the medical profession for:				
a.	High blood pressure, elevated cholesterol, chest pain, heart murmur, cardiac arrhythmia, or any disease or disorder of the blood vessels, coronary disease including coronary artery disease (CAD) or arteriosclerotic heart disease (ASHD)?	☐	☐	☐	☐
b.	Epilepsy, fainting, stroke or transient ischemic attack (TIA), depression, mental or nervous disorder, psychiatric disorder, Alzheimer's disease, dementia or memory loss, or taking medication for dementia or memory loss?	☐	☐	☐	☐
c.	Diabetes, any complications of diabetes including but not limited to amputation, eye or kidney problems, insulin shock or diabetic coma, thyroid or other endocrine disorders?	☐	☐	☐	☐
d.	Rheumatoid arthritis, multiple sclerosis, any disease or disorder of the bones or muscles or muscular dystrophy including Lou Gehrig's Disease (ALS)?	☐	☐	☐	☐
e.	Melanoma, internal cancer or any additional growth or tumor?	☐	☐	☐	☐
f.	Any disease or disorder of the lungs or respiratory system (including shortness of breath and asthma), chronic obstructive pulmonary disease (COPD), emphysema or the current use of oxygen?	☐	☐	☐	☐
g.	A disorder of the kidneys, prostate, breasts or uterus?	☐	☐	☐	☐
h.	A disorder of the stomach, intestines, or liver; Crohn's disease; ulcerative colitis; gastrointestinal bleeding; unexplained weight loss; systemic lupus; or hepatitis?	☐	☐	☐	☐
4.	Within the past 5 years, has any Proposed Insured been an inpatient or outpatient in a hospital, clinic or medical facility, or had any diagnostic test not related to the conditions listed above?	☐	☐	☐	☐
5.	Has the Proposed Insured tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? (**If YES, DO NOT** provide details in the Medical History Details section below.)	☐	☐	☐	☐

SECTION F. MEDICAL HISTORY *(Provide details of all "Yes" answers in the Medical History Details section below.)*

		Primary Insured	Additional Insured
6.	Is any Proposed Insured currently on any medications or treatment or been advised by a licensed member of the medical profession to have tests or surgery which have not been completed within the last 12 months?	☐ ☐	☐ ☐
7.	Has any Proposed Insured ever used heroin, morphine, or other narcotics, marijuana, cocaine, barbiturates, amphetamines, hallucinogenic drugs or other habit forming drugs except as prescribed by a licensed member of the medical profession?	☐ ☐	☐ ☐
8.	Within the past 7 years, has any Proposed Insured been treated for or been advised by a licensed member of the medical profession to have treatment for, or to reduce or discontinue the intake of alcohol or prescription drugs?	☐ ☐	☐ ☐
9.	Please provide the full name, address and phone number of any personal physician(s):		

Name of Personal Physician	Address	Phone Number	Primary Insured	Additional Insured
			☐	☐
			☐	☐
			☐	☐

MEDICAL HISTORY DETAILS

Please provide details of all "Yes" answers in the area below. *(Attach a separate sheet if more space is needed; additional sheet MUST be signed and dated by applicable Insured/Owner to avoid amendments.)*

Question #	Date of Onset/ Treatment	Details/Results	Name, Address, and Telephone Number of Attending Physician	Primary Insured	Additional Insured
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION G. SECONDARY DESIGNEE INFORMATION

1. Do you wish to designate another person the right to receive notice of an impending lapse or termination of the policy for in the event of nonpayment of premium? ☐ Yes ☐ No If YES, complete information below.

a. Secondary Designee's Name: (Last, First, MI)

b. Address (Include City, State, and ZIP)

c. Phone Number ☐ Home ☐ Cell ☐ Work

AUTHORIZATION AND ACKNOWLEDGMENT

FRAUD NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

REQUEST FOR OWNER(S) TAXPAYER IDENTIFICATION NUMBER AND W-9 CERTIFICATION: Under penalties of perjury, I as the Owner certify that:

1. **I am a U.S. citizen or other U.S. person, and 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.**

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.

By providing Your Authorization and Acknowledgment, You:

- **AGREE** any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction where the Owner resides at the time of the application, as evidence by the address provided in this application.

- **ACKNOWLEDGE** that the USA PATRIOT ACT requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows Americo to verify your identity. Americo's verification process may include the use of third-party sources to verify the information you provide.

- **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 Primary Insured or Parent if Primary Insured is under the age of majority	Signature of Owner/Trustee/Parent (if applicable)	Owner Title/Relationship
Printed name of Primary Insured or Parent above	Printed name of Owner/Trustee/Parent above	Signature of Additional Insured (if applicable)
Signature of Witnessing Agent	Print Agent's Name (if applicable)	_____/_____ Agent Number/Florida License Number
Agent Phone Number	Agent Fax Number	Agent E-mail Address

Name of Agent(s) to whom commissions are to be paid:

Name	Agent #	% Split	Name	Agent #	% Split