

# Life Insurance Application

## INSTRUCTIONS

*Please print on all areas of the application*

1. Fill out and sign the life insurance application.
  - Make sure the ZIP code is included in the primary insured's mailing address (pg. 1).
  - Remember to fill in the beneficiary's full name and relationship to the primary insured (pg. 1).
  - Under Product Name (pg. 2), write the marketing name of the plan of insurance.
  - Remember to fill out the complete addresses and phone numbers for all doctors and hospitals (pgs. 5-6).
  - Remember to fill out the replacement question in the Agent Certification section (pg. 7).

Submit application to:

Mailing Address:

Fidelity and Guaranty Life Service Center  
P.O. Box 19040  
Greenville, SC 29602-9040

Americom Life and Annuity Service Center  
P.O. Box 81337  
Lincoln, NE 68501-1337

Overnight Address:

Fidelity and Guaranty Life Service Center  
201 Brookfield Parkway, Suite 300  
Greenville, SC 29602

Americom Life and Annuity Service Center  
421 S. 9th Street, Suite 222  
Lincoln, NE 68508

**NOTE: As applicants will automatically be assigned to the best underwriting class for which they qualify, it is not necessary to indicate the desired underwriting class on the application.**

2. If the primary insured or owner lives in a state where one of the fraud warnings applies, fill out and sign the "Fraud Warning Notices" page (pg. 8).
3. If the primary insured or owner is applying for spousal coverage, fill in Other Insured section (pg. 1). If Children's Insurance is being applied for, use the Children's Insurance Supplement, Admin 4948.
4. Use the space following the Medical Questions for any "yes" answers. If more space is required to explain any "yes" answers or for any other reasons, fill out the "Additional Information" section (pg. 8) and sign it.
5. For Corporate/Business proposed insureds, fill out the Life Financial Supplement form, Admin 2822. Earned Annual Income is defined as net income after expenses and before taxes.
6. For bank draft payment modes, sign and date the "Bank Draft Plan: EFT Premium Authorization to My Bank" page (final page in application packet). Attach a voided check.
7. Credit card processing is available for the initial payment only. If elected, please be sure to also complete the Mode of Payment section (pg. 2) for subsequent payments.
8. If cash is paid with the application, fill out the "Life Insurance Conditional Receipt" stub (first page after application) and leave it with the applicant. Otherwise, discard it.
9. Leave the page containing the "Investigative Consumer Report Pre-Notification" and the "MIB Pre-Notification" with the applicant (second page after application).
10. All supplemental questionnaires/forms are viewable and orderable on SalesLink at [www.fglife.com](http://www.fglife.com). Forms are available for the following:  
Motorsports; Residence & Travel; Military; Arthritis; Back Disorders; Diabetes; Growths, Cysts & Tumors; Climbing; Diving; Aviation; Parachuting; Gliding, Hang Gliding and Ultra-Lighting; Children's Insurance; Paramed Form; Reinstatement Application; and Critical Illness Coverage.

**Not a deposit • Not FDIC insured • Not insured by any Federal Government Agency • Not guaranteed by a financial institution (such as a bank, savings association, or credit union) • The financial institution may not condition an extension of credit on the consumer's purchase of an insurance product or an annuity from the financial institution or any of its affiliates. The consumer is free to purchase the insurance product or annuity from another source.**

# Life Insurance Application (page 1 of 8)

## INSURER

Fidelity & Guaranty Life Insurance Company  
[(888) 513-8797]

Americom Life & Annuity Insurance Company  
[(866) 746-2624]

*IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT ANY OF THE CONTENTS OF THIS FORM OR THE INSURANCE COVERAGE OR WISH TO DISCUSS THE INSURANCE COVERAGE, CALL OUR HOME OFFICE (AT THE TELEPHONE NUMBER LISTED UNDER THE COMPANY YOU ARE APPLYING FOR COVERAGE TO).*

## PRIMARY INSURED

Name (First, M.I., Last)

Home Address

Social Security No. | Sex | Marital Status | Date of Birth | Place of Birth | Height (ft., in.) | Weight (lbs.)

Currently Employed? | Occupation and Duties | Place of Employment | Years w/ Current Employer  
 Yes  No

Earned Annual Income (from last year's W-2) | Drivers License Number and Issue State

Daytime Phone | Evening Phone | Best Time to Call | Email Address

## OTHER INSURED

Name (First, M.I., Last) | Relationship to Primary Insured

Home Address

Social Security No. | Sex | Marital Status | Date of Birth | Place of Birth | Height (ft., in.) | Weight (lbs.)

Currently Employed? | Occupation and Duties | Place of Employment | Years w/ Current Employer  
 Yes  No

Earned Annual Income (from last year's W-2) | Drivers License Number and Issue State

Daytime Phone | Evening Phone | Best Time to Call | Email Address

## OWNER(S)

*(UNLESS OTHERWISE NOTED, THE OWNER WILL BE THE PRIMARY INSURED.)*

Name (First, M.I., Last) | Relationship to Primary Insured

Home Address

Home Phone | Email Address

Birth Date | Social Security No. or Tax I.D. No.

## BENEFICIARY DESIGNATION - Primary Insured Coverage

*FOR EACH BENEFICIARY, LIST FULL NAME, RELATIONSHIP TO PRIMARY INSURED AND % SHARE.*

Primary Beneficiary(ies)	%	Contingent Beneficiary(ies)	%

## BENEFICIARY DESIGNATION - Other Insured Coverage

*Unless otherwise noted in the Additional Information section, the beneficiary of other persons proposed for coverage will be the Primary Insured.*

FIDELITY AND GUARANTY LIFE INSURANCE COMPANY, Baltimore, Maryland • AMERICOM LIFE AND ANNUITY INSURANCE COMPANY, Houston, Texas





# Life Insurance Application (page 4 of 8)

## PERSONAL HISTORY QUESTIONS

	Primary Insured	Other Insured
1. Are you a citizen of the United States? If "No", what is your citizenship? Immigration status? Type of visa?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
2. Have you traveled or resided outside the United States or Canada within the past 2 years?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
3. Do you plan to travel or reside outside the United States or Canada within the next 2 years?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
4. Have you been convicted of a felony or are currently on parole for any offense?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
5. In the past 10 years have you been convicted of DWI/DUI?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
6. In the past 5 years have you had any speeding tickets or other driving violations?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
7. In the past 5 years have you participated in ballooning, bungee jumping, cliff diving, hang gliding, motorized racing, parachuting, mountain or rock climbing, skin or scuba diving, or any similar avocation?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
8. In the past 5 years have you flown as a pilot, student pilot, or crew member of an aircraft?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
9. In the past 10 years have you ever sought or received treatment, advice, or counseling for the use of alcohol?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
10. Have you ever sought or received treatment, advice, or counseling for the use of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
11. Have you ever been arrested for the use or possession of such drug or are you currently using these drugs?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
12. Within the past 10 years have you made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
13. Within the past 7 years, have you filed for bankruptcy?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
14. <i>(Only required when applying for HomeCertain term insurance)</i> In the past 13 months have you contracted for a home mortgage, or refinanced an existing mortgage? If the answer is yes, please list the amount of the mortgage or refinancing, and the name and address of the lending institution.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

***Detail all Yes answers below (additional information may be required).  
In addition, complete questionnaires for YES answers to Questions 2, 5, and 6.***

### Primary Insured

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### Other Insured

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## PERSONAL PHYSICIAN INFORMATION – Primary Insured

*(Provide full name, address, and phone number of personal physician (other than for a medical consultation or informational visit concerning AIDS or AIDS Related Complex ARC). Please write "NONE" if primary insured does not have a personal physician.)*

Name \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Reason for Last Visit \_\_\_\_\_

Result of Last Visit \_\_\_\_\_

## PERSONAL PHYSICIAN INFORMATION – Other Insured

*(Provide full name, address, and phone number of personal physician (other than for a medical consultation or informational visit concerning AIDS or AIDS Related Complex ARC). Please write "NONE" if primary insured does not have a personal physician.)*

Name \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Reason for Last Visit \_\_\_\_\_

Result of Last Visit \_\_\_\_\_

# Life Insurance Application (page 6 of 8)

## MEDICAL HISTORY QUESTIONS

	Primary Insured	Other Insured
1. Have you ever been treated for or diagnosed with:		
a) Any heart disease, heart attack, chest pain, high blood pressure, high cholesterol, murmur, palpitations, or any other disorder of the heart or blood vessels?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
b) Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
c) Any breathing or lung disorders, COPD, asthma, bronchitis, sleep apnea, or emphysema?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
d) Diabetes, disorder of the immune system, blood disorder, or disorder of the glands?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
e) Cancer, tumor, or cyst?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
f) Depression, anxiety, dementia, Alzheimer's, or any other mental or nervous disease or disorder?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
g) Hepatitis, gastritis, colitis, or any disease or disorder of the liver, stomach, pancreas, or intestines?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
h) Any disease or disorder of the kidneys, bladder, prostate, urinary, or reproductive systems?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
i) Arthritis or any disease or disorder of the muscles (to include strains or sprains), tendons, bones, spine, back, or joints?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
j) Any disease or disorder of the skin, eyes, or ears?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
k) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive test results indicating the presence of the AIDS virus?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
2. Are you currently prescribed any medication?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
3. Have you been prescribed medication in the past 5 years not previously mentioned?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
4. In the past 10 years, have you:		
a) Been hospitalized or had surgery?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
b) Had any electrocardiograms, x-rays, laboratory tests, treatments, or procedures?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
c) Been recommended to have any test, treatment, or surgery which has not been performed?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
d) Had any illness, disease, or injury that is not included in other answers?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
5. Has any parent, brother, or sister died from or had any occurrence of cancer, heart disease, diabetes, or any hereditary disease prior to age 60?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
6. Have you smoked cigarettes, pipes, or cigars, used snuff, chewed tobacco, or used any nicotine based product such as patch or gum? If yes, please detail the type(s) of tobacco product used and date of last use below.	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

*Detail all Yes answers (Include name of treating physician, diagnosis, date of diagnosis, and location of medical records)*

### Primary Insured

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### Other Insured

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# Life Insurance Application (page 7 of 8)

## AUTHORIZATION

I have read the questions and answers on this application. The statements made in this application are: complete; true; and correctly recorded. **I agree that: a copy of this application will form a part of any certificate/policy issued; and that no agent can pass on insurability or modify any certificate issued by the Insurer. I also agree that, except as provided in this application's Receipt, if issued, no insurance will take effect unless and until both of the following conditions are satisfied during each proposed insured's lifetime and while each proposed insured's health is as stated in this application: (1) this certificate/policy is delivered to and accepted by the Owner; and (2) the full initial premium for the mode of payment chosen is paid at our Home Office.** I acknowledge that I have received, read and understand the notices required by: the Medical Information Bureau, Inc.; and the Federal Fair Credit Reporting Act regarding investigative consumer reports.

I authorize any licensed physician, medical practitioner, hospital, clinic, the Veterans Administration, laboratory or other medical or medically-related facility, the Medical Information Bureau, Inc., insurance companies, a consumer reporting agency, prescription records, Pharmacy Benefit Manager, and my employer to give to the Insurer, its reinsurers, or other designee, medical and other information which may be pertinent to the evaluation regarding me or any member of my family who is applying for life insurance.

I also authorize the Insurer to obtain an investigative consumer report on me or on any member of my family who is also applying for life insurance. I understand that I am entitled to be interviewed by any consumer reporting agency which may be requested to prepare such a report as long as I can reasonably be contacted during normal business hours. Check if interview requested:

I understand that if my coverage includes the Accelerated Benefit Rider and I am later diagnosed with a terminal condition as defined in the rider, I may receive up to 50% of the certificate or policy's death benefit. Since I would receive a portion of my benefits early, the amount payable at the time of my death will be reduced. There is no premium charged for this rider. I understand that receipt of benefits may be taxable, and that the Insurer recommends consultation of a tax advisor prior to exercising this benefit.

I further understand that if I am purchasing a HomeCertain term life product, the mortgage information I supplied will be relied upon to determine my insurability for that product, in conjunction with my health information. As such, inaccurate information about my mortgage may result in a denial, rating, or rescission of my insurance coverage.

I authorize the Insurer and/or its reinsurer(s) to release information in my file to other insurance companies to which I may apply for life or health insurance coverage or to which a claim may be submitted.

This Authorization will be valid from the date signed for a period of 30 months; a photographic copy of this Authorization will be as valid as the original; I, or any of our representatives are entitled to receive a copy of this Authorization.

I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or benefits.

**Certification:** Under the penalties of perjury, I certify that my Social Security or Tax Identification Numbers provided on this form are true, correct and complete.

\_\_\_\_\_  
Signed at (City and State) on (Date)

\_\_\_\_\_  
Signature of Primary Insured age 15 or more

\_\_\_\_\_  
Signature(s) of Additional Insured(s) age 15 or more

\_\_\_\_\_  
Signature of Owner(s) (if not the Primary Insured or if Primary Insured is less than age 18)

## AGENT CERTIFICATION

1) I have asked the questions contained in this application of the Insured(s) and Owner and duly recorded the answers; 2) to the best of my knowledge there is nothing affecting the insurability of any persons proposed for insurance as stated in this application; 3) if the initial premium was paid with the application, I have remitted it to the Insurer and delivered a Conditional Receipt to the Owner; 4) if Disclosure Statements are required by the state, I have given them to the applicant; 5) I have witnessed the signatures on this application.

**To the best of my knowledge, this application**  **does replace**  **does not replace existing life insurance or annuities.**

If so, will this replacement be considered a 1035 Exchange?  Yes  No

Signature of Agent

Date

Print Agent's Name

Agent Number

Agent's Phone Number

Agent's Fax Number

Agent's Email Address

# Life Insurance Application (page 8 of 8)

Complete and sign this page if additional space is needed or if the primary insured or owner lives in a state where one of the fraud warnings applies.

## ADDITIONAL INFORMATION

If additional space is needed to expand on any section, please use the space below.

Section	Question	Primary Insured	Other Insured	Detail
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	
		<input type="radio"/>	<input type="radio"/>	

## FRAUD WARNING NOTICES

(Please review the notice that applies in your state)

- AR/LA:** 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.
- CO:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a certificate holder or claimant for the purpose of defrauding or attempting to defraud the policy or certificate holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department regulatory agencies.
- DC:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- KY/OH:** I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud. \_\_\_\_\_ (Owner's Initials).
- ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefit.
- NJ:** Any person who includes any false or misleading information on an application for an insurance policy/certificate is subject to criminal and civil penalties.
- OK:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- NM/PA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- TN:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at (City and State) on (Date)

Signature of Primary Insured age 15 or more

Signature(s) of Additional Insured(s) age 15 or more

Signature of Owner(s) (if not the Primary Insured or if Primary Insured is less than age 18)

# Life Insurance Application

*Leave this page with applicant if cash is paid with application.*

## LIFE INSURANCE CONDITIONAL RECEIPT

**PLEASE READ THIS CAREFULLY. All premium checks must be made payable to:**

- Fidelity and Guaranty Life Insurance Company (hereinafter "Insurer")
- Americom Life and Annuity Insurance Company (hereinafter "Insurer").

**Do not make check payable to agent/producer or leave payee blank.**

Received from \_\_\_\_\_ a check in the amount of \$\_\_\_\_\_ paid with a life insurance Application to the Insurer. The Application bears the same date as this Receipt. I have advised each proposed insured of the terms, conditions, and limitations of this Conditional Receipt. No agent or broker is authorized to alter the terms of this Receipt, waive any terms or conditions, or pass on insurability.

No agent or broker is authorized to alter the terms of this Receipt, waive any requirements, or pass on insurability.

Dated at (City & State)

On (Date)

Agent's Signature

The life insurance contract you have applied for will not provide insurance coverage unless and until a contract is delivered to you. However, subject to the terms, conditions, and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy/certificate applied for will become effective prior to policy/certificate delivery under the following conditions.

This Receipt will provide life insurance starting at the Effective Date. The Effective Date is the latest date of the following events:

- Signing of all parts of the Application, including any supplement, addenda, or amendment to the Application, and completion of any medical examination portion of the Application;
- Date requested in the Application that is agreed to by the Insurer;
- The full initial premium for the mode of payment chosen is received at our Home Office; or
- Any additional information required by us, including attending physician statement/report, is received at our Home Office.

This Receipt will provide no life insurance unless and until each of the following Requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- As of the Effective Date hereinabove defined, each person proposed to be insured is found to be insurable exactly as applied for in the Application submitted to the Insurer and in accordance with the Insurer's underwriting rules and standards, without any modification as to life insurance product, amount of life insurance coverage, or premium rate;
- The payment taken with the Application is not less than the full initial premium for the mode of payment chosen in the Application and is honored immediately upon presentment;
- All medical examinations, tests, and other screenings required by the Insurer are completed, with results received at the Insurer's Home Office within 60 days from the date of the completion of the Application; and
- As of the Effective Date, the health and all factors affecting the insurability of each person proposed to be insured are as stated in the Application.

If all Requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Insurer shall be limited to a full refund to the Applicant of the premium payment received by the Insurer.

This Receipt will terminate on the earliest date of:

- 60 days from the date this Receipt was executed;
- The date the Insurer mails notice to the Applicant of the rejection of the Application for insurance;
- The day before the date insurance goes into effect under the policy/certificate applied for; or
- The date the Insurer offers insurance other than as applied for.

The aggregate amount of life insurance provided on the life of any person proposed to be insured which may become effective under this Receipt and any other Conditional Receipt issued by the Insurer on the life of that person, shall be the lesser of the amount applied for or \$500,000.

This Receipt provides no insurance for riders or additional benefits.

# Life Insurance Application

*Leave this page with applicant.*

## **INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION** to Primary Insured And Other Persons Proposed to be Insured, If Any

We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon your written request, let you know whether a report was requested and, if so, give you the name, address and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report.

Typically, the report will contain information as to character, general reputation, personal characteristics, health, job and finances. When applicable, it will contain information on your: past and present employment record (including job duties); driving record; health history; use of alcohol or drugs; sport, hobby or aviation activities; and marital status. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors and others you know.

## **MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION** to Primary Insured And Other Persons Proposed to be Insured, If Any

Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105; Essex Station; Boston, Massachusetts 02122; telephone number (617) 426-3660.

We or our reinsurer(s) may also release information in our file to other insurance companies to which you may apply for life or health insurance coverage or to which a claim may be submitted.

# Life Insurance Application

## BANK DRAFT PLAN

Please attach a voided check here in addition to your initial premium.

## BANK DRAFT PLAN: EFT PREMIUM AUTHORIZATION TO MY BANK

I authorize the payment of debits drawn on my account payable to the insurer, provided there are sufficient funds in said account. I agree that if any such debit be dishonored, the insurer has the right to debit my account the following month for the dishonored debit as well as the scheduled debit for that month. I further agree that if any debit be dishonored, you shall be under no liability in the event the dishonored debit results in the forfeiture of insurance. This authority shall remain in effect until revoked by me in writing and until you actually receive such notice of revocation.

Signature (as it appears on bank records)

Date





## HIPAA Authorization for Release of Medical Information

Name of Proposed Insured (please print or type)

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, 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") to disclose my entire medical record, medications prescribed and any other protected health information concerning me to FIDELITY & GUARANTY LIFE INSURANCE COMPANY (F&G LIFE) & AMERICOM LIFE & ANNUITY (AMERICOM). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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 physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that F&G LIFE & AMERICOM 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 F&G LIFE & AMERICOM.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. 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, 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 F&G LIFE & AMERICOM 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 re-disclosed by F&G LIFE & AMERICOM 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. I further understand that if I refuse to sign this authorization to release my complete medical records, F&G LIFE & AMERICOM 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.

Release all medical records to MID-AMERICA AGENCY SERVICES, INC. (MAAS), 1205 7<sup>TH</sup> STREET, HARLAN, IOWA 51537 (712-755-2700)authorized representative for F&G LIFE & AMERICOM.

Signature of Proposed Insured or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

# Notice and Consent for Blood, Urine or Saliva Testing



## Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

Examiner

Insurer

Address

Address

To determine your insurability, the Insurer named above has requested that you provide a sample of your blood, urine or saliva for testing and analysis. All tests including HIV antibody/antigen testing as described below, will be performed by a licensed laboratory unless you otherwise request, by checking here , to have the HIV antibody/antigen testing performed by a testing site operated or funded by Pennsylvania's state, county or municipal health departments. (Under this scenario, it will be necessary for you to provide the two blood samples for testing and analysis.) Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

### Confidentiality

All test results will be treated confidentially. They will be reported by the testing facility to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

### Notification of Test Results

If your HIV test results are normal, no routine notification will be sent to you unless you request to be so notified by checking here . If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician (or other health care provider) or, alternatively, one of the community-based organizations listed on page 2 of this form to whom you may authorize disclosure and with whom you may wish to discuss the result.

### Significance of Positive Test Results and Effect on Application for Insurance

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant test abnormalities may adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy charges may be necessary.

I have read and I understand this Notice of Consent for blood, urine or saliva testing which may include AIDS virus HIV antibody/antigen testing. I voluntarily consent to withdrawal of blood sample from me by needle or the submission of a urine or saliva sample by me, the testing of that sample and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (print)

Date of Birth

Signature of Proposed Insured or Parent/Guardian

Date

Address and State of Residence

Fidelity and Guaranty Life Insurance Company Baltimore, Maryland

FGL 3481 (8-97) PA

Original: F&G Life

Copy: Applicant

Copy: Agent

Because of the serious nature of HIV-related illnesses, you may wish to obtain counseling before undergoing HIV-related testing. If you so desire to do this, do not sign this form until after you have obtained such counseling. Information on HIV counseling and testing sites may be secured by contacting:

	Pennsylvania Department of Health Bureau of HIV/AIDS P.O. Box 90 Harrisburg, PA 17106	(717) 783-0479
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Or the company-based organizations listed below:

Allegheny	Pittsburg AIDS Task Force 141 South Highland Avenue Pittsburgh, PA 15206	(412) 363-2437
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Philadelphia	Philadelphia Community Health Alternatives (PCHA) 1642 Pine Street Philadelphia, PA 19103	(215) 735-1911
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	Congreso-De Latinos Unidos, Inc. Programa Esfurzo 704 West Girard Avenue Philadelphia, PA 19123	(215) 223-3880
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	BEBASHI 5202 North Broad Street Philadelphia, PA 19141	(215) 546-4140
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