F PROPOSED INSURED HEALTH INFORMATION

☐ N/A – Guaranteed Issue Product Elected.

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 for any reason; Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

Signature located on Medical Information Authorization

Signature of Proposed Insured *(required)* _____ Date _____

1. Have You smoked cigarettes within the last twelve (12) months? ☐ Yes ☒ No

2. Height: 5'7" | 3. Weight: 171

		Yes	No
4.	To the best of Your knowledge and belief, have You ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a licensed member of the medical profession for:		
	a. Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's disease)?	☐	☒
	b. Congestive heart failure or cardiomyopathy, chronic kidney disease or kidney failure, or received kidney dialysis?	☐	☒
	c. Cirrhosis of the liver, liver failure or other liver diseases (excluding Hepatitis A, B, or C)?	☐	☒
	d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic respiratory or lung problem, excluding allergies or asthma?	☐	☒
	e. Metastatic cancer (cancer that has spread to other parts of the body)?	☐	☒
	f. Two (2) or more occurrences of cancer of any kind or a reoccurrence of a previous cancer?	☐	☒
5.	In the past twenty-four (24)months, have You been diagnosed, treated, tested positive, or been given medical advice by a licensed member of the medical profession for:		
	a. Internal cancer or malignant melanoma (not basal cell skin cancer)?	☐	☒
	b. Complications of diabetes, including amputation, retinopathy (eye disease), nephropathy (kidney disease), neuropathy, insulin shock, or diabetic coma?	☐	☒
	c. Chronic hepatitis or alcoholic hepatitis?	☐	☒
6.	To the best of Your knowledge and belief, have You ever tested positive for exposure to the HIV infection or been diagnosed by a licensed member of the medical profession as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☒
7.	In the past twenty-four (24) months, have You received a diagnosis, been treated, received medical treatment or counseling, or been prescribed medication by a licensed member of the medical profession for drug or alcohol abuse/dependency or addiction?	☐	☒
8.	Within the last twelve (12) months, have You been advised by a licensed member of the medical profession to have tests, surgery or hospitalization (except for those related to HIV or AIDS), which have not been completed, or waiting for a medical diagnosis or results of medical tests or procedures which have not been received?	☐	☒
9.	In the past twelve (12) months, have You been diagnosed, treated, tested positive, prescribed medication, or been given medical advice by a licensed member of the medical profession for:		
	a. Angioplasty (balloon procedure), stent placement, or heart bypass surgery?	☐	☒
	b. Stroke; Heart attack, heart valve disorder, coronary disease, angina (chest pain), or heart disorder (excluding heart murmurs, rhythm disorders, and hypertension)?	☐	☒
10.	Have You received advice from a licensed member of the medical profession to have, are You waiting for, or have You ever received, an organ or tissue transplant?	☐	☒
11.	Are You now, or within the past six (6) months have you been:		
	a. Hospitalized for 48 hours or more, bedridden or confined to or living in a nursing facility or correctional facility?	☐	☒
	b. Receiving or been advised by a licensed member of the medical profession to receive hospice care?	☐	☒
	c. Receiving home health care for a chronic or debilitating condition?	☐	☒
	d. Receiving assistance with activities of daily living , including eating, bathing, toileting, or dressing due to a chronic or debilitating condition?	☐	☒
	e. Confined to a wheelchair or using a walker for a chronic illness (except in the case of a temporary condition that is expected to last three (3) months or less)?	☐	☒
	f. Using oxygen to assist in breathing?	☐	☒
12.	Have You been diagnosed with a terminal illness that is expected to result in death within twenty-four (24) months?	☐	☒

ADDITIONAL QUESTIONS FOR APPLICANTS AGE 40-49 ONLY | **Yes** | **No**

13. Within the past twenty-four (24) months, have You been convicted of, or pled guilty or no contest to, a felony? ☐ ☐
14. Within the past twenty-four (24) months, have You been diagnosed, treated or tested positive, or given medical advice by a licensed member of the medical profession for:
    a. Bipolar disorder, schizophrenia, manic or clinical depression, psychosis, mental incapacity, post-traumatic stress disorder or suicidal thoughts? ☐ ☐
    b. Brain tumor? ☐ ☐
    c. Huntington's disease? ☐ ☐
15. Within the past twenty-four (24) months, have You used narcotics (other than as prescribed by a licensed member of the medical profession), amphetamines, hallucinogens, heroin, or cocaine? ☐ ☐
16. Within the past twelve (12) months, have You been convicted of or pled guilty or no contest to driving while impaired, intoxicated or under the influence of drugs or alcohol, or had Your driver's license suspended or revoked for any reason? ☐ ☐
17. Within the past twelve (12) months, have You been diagnosed, tested positive, or been given medical advice by a licensed member of the medical profession for chronic pancreatitis? ☐ ☐
18. Do You currently have felony charges pending against You, or are You currently on probation or parole? ☐ ☐

G AUTHORIZATION AND ACKNOWLEDGMENT

IMPORTANT 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.

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) Orlando, Florida FL on (Month/Day/Year) 6/7/2018

Signature of Proposed Insured *(required)* | Signature of Owner *(if different than Proposed Insured)*

DocuSigned by

Signature of Witnessing Agent (*required*) | Witnessing Agent's Name *(printed)* | Agent's FL ID#