American Fidelity Assurance Co
AFAmeriLife Division

PO Box 268923 – Oklahoma City, OK 73126-8923

EZ-FORM

- Exam will be ordered by EMSI
- Maximum face amount $500,000
- No payment or cash accepted with this form
- Fax this form to: 800-530-0504

Proposed Insured Information

Last Name (Maiden Name) First Name Full Middle Name Suffix

Address City State Zip

Gender ❑ Male ❑ Female Date of Birth Soc Sec Number State of Residence

Home Phone #: ( ) Cell Phone #: ( ) Business Phone #: ( )

Best time to call: ❑ 8:00 AM – 12:00 PM ❑ 12:00 PM – 4:00 PM ❑ 4:00 PM – 8:00 PM

Phone number to call: ❑ Residence ❑ Business ❑ Other ( )

What is the primary language spoken by the applicant, if other than English:

This Form/Process Is Not Available If This Policy Will Replace Any Existing Coverage(s).

Plan Information

POLICY SELECTION	PREMIUM CLASS
❑ Alternative 95 – Participating Initial Benefit Amount $________________ Annual Premium $ ________________	❑ Preferred Non-Tobacco ❑ Standard Non-Tobacco ❑ Standard Tobacco
❑ Ultimate 95 – Non-Participating Initial Benefit Amount $________________ Annual Premium $ ________________	❑ Preferred Non-Tobacco ❑ Standard Non-Tobacco ❑ Standard Tobacco
❑ Secured Life Plus (SL+) Benefit Amount $ ________________ Annual Premium $ ________________	❑ Standard Non-Tobacco ❑ Standard Tobacco
❑ AmeriTerm Initial Term Period: ❑ 20 Yrs ❑ 30 Yrs Benefit Amount $ ________________ Annual Premium $ ________________	❑ Super Preferred Non-Tobacco ❑ Preferred Non-Tobacco ❑ Standard Non-Tobacco ❑ Preferred Tobacco ❑ Standard Tobacco

RIDER SELECTION

❑ Waiver of Premium
Annual Premium $ ____________

❑ Accidental Death
Benefit Amount $ ____________
Annual Premium $ ____________

❑ Accident Disability Income
Benefit Amount $ ____________
Annual Premium $ ____________

❑ Return of Premium
Annual Premium $ ____________

❑ Children's Term
Benefit Amount $ ____________
Annual Premium $

Has the proposed insured ever used any form of tobacco or nicotine-based products? ❑ **Yes** ❑ **No**
If "Yes", provide history of use: Date last used:

Billing Frequency (mode): ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly PAC
If Monthly PAC is chosen, you must complete the Monthly Bank Draft Authorization.

Primary Beneficiary First Name MI Last Name Soc Sec / Tax ID Number

Agent Report / Suitability and Acknowledgement

To help you and your agent make a suitable decision please answer these questions:
I'm applying for life insurance to solve a need for? (Check all that apply or explain.)

❑ Income replacement ❑ Debts or mortgage ❑ Dependent protection ❑ Business needs
❑ Inheritance planning ❑ Gifting ❑ Final expenses

Explain: ____

The method I have discussed with my agent to determine the amount of life insurance to apply for is: (Check or explain.)

❑ Percent of income ❑ Human life value ❑ Specific needs (such as: mortgage, debt, other)

Explain: ____

I have reviewed a copy of consumer brochure # _____________ and my agent has discussed features and benefits of this life insurance.

Agent Data

By signing this form, I state the following:

1. I am a duly licensed and appointed life insurance agent in the state in which the application was solicited and the policy, if one is issued, will be delivered.
2. The plan and amount of insurance identified is suitable in view of the applicant's insurance needs and financial objectives.

I also acknowledge and agree to the following conditions:

1. I agree to allow an American Fidelity representative to interview the applicant to complete the remainder of the application process.
2. I have provided to American Fidelity a copy of my legal signature, which will be affixed electronically to the completed application resulting from the above interview.
3. I agree to review the approved policy and application and deliver to the applicant.
4. If applicable, I agree to review and explain the content of any required illustration to the applicant. I will return a copy signed by myself and the applicant to the Home Office.

______________________________	______________________________	______________
Print Agent's Name and AFA Agent Code #	**Agent's Signature**	**Date**

Authorizations

I authorize the Medical Information Bureau (MIB) if it has any records or knowledge of me or of my health to give American Fidelity Assurance Company or its reinsurers any such information. This authorization includes information about drugs, alcoholism or mental illness. **NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For California residents, this does not require disclosure of prior HIV-related tests.** I authorize American Fidelity Assurance Company or its reinsurers to release my nonpublic financial or medical information in its files to the MIB, to other life insurance companies to whom I may apply for life or health insurance, and to other entities as permitted by law. I understand any such life insurance companies must first agree in writing to maintain the confidentiality of such information and to provide American Fidelity Assurance Company with my written authorization prior to any release of information about me. This authorization will expire two years from the date shown below. (In Arizona release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days.) A copy of this authorization will be as valid as the original. I understand that the information collected will be used to determine my eligibility for insurance. I am aware that I, or my authorized representative may receive a copy of this authorization. I understand that this authorization may be revoked at any time by providing written notice to American Fidelity Assurance Company. I have received a copy of the Notice to Applicant for Insurance and the MIB notice. To the best of my knowledge and belief, the statements and answers given on this form are true, complete and correctly recorded. I have considered my present insurance needs and determined that the purchase of this insurance is not unsuitable for me.

I understand that no liability exists for American Fidelity Assurance Company until a policy is delivered to and accepted by the owner and the first premium is paid during the lifetime of the proposed insured.

American Fidelity Assurance Company and its reinsurers agree to maintain the confidentiality of all the Proposed Insured's nonpublic financial or medical information given to us by the authorized entities listed above.

I authorize American Fidelity Assurance Company or its representatives to contact me regarding its products and services at the telephone numbers listed above.

______________________________	______________________________
Signed At (City and State)	**Date Signed**
______________________________	______________________________
Print Proposed Insured	**Signature of Proposed Insured**

BOTH SIDES OF THIS FORM MUST BE FAXED TO: 800-530-0504