

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

- ✓ Rates never increase
- ✓ Lifetime benefit<sup>1</sup>
- ✓ No medical exams - just a few simple questions to answer<sup>2</sup>
- ✓ Guaranteed qualification<sup>3</sup>
- ✓ Income tax-free death benefit<sup>4</sup>
- ✓ Terminal Illness Accelerated Benefit Rider on Ultra Protector I
- ✓ Coverage available for eligible children and grandchildren on Ultra Protector I
- ✓ Coverage cannot be cancelled because of age or health

*1) As long as premiums are paid and there are no loans or accelerations. 2) Issuance of policy may depend upon answers to medical questions. 3) Subject to age limits. 4) Neither Amerigo Financial Life and Annuity Insurance Company nor any agent representing Amerigo Financial Life and Annuity Insurance Company is authorized to give legal or tax advice. Please consult a qualified professional regarding the information and concepts contained in this material.*

### Ultra Protector Series offers three products to fit every need:

### How do I qualify?

#### Ultra Protector I - Full Death Benefit Day One

- ▶ Children's Term Rider (Rider Series 2147)
- ▶ Accelerated Benefit Payment Rider (Rider Series 2146), included at no additional cost

All health questions on the application are answered "no" (both parts 1 and 2).\*

#### Ultra Protector II - 2-year graded death benefit

- ▶ Accidental Death Benefit Provision, included at no additional cost

All health questions in Part 1 are answered "no", one or more questions in Part 2 are answered "yes."\*

#### Ultra Protector III - 3-year 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.

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

\*MIB 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 281/282/283), Children's Term Rider (Rider Series 2147), and the Accelerated Benefit Payment Rider (Rider Series 2146) are underwritten by Amerigo 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.



**5. REPLACEMENT INFORMATION**

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? **If Yes, provide information below and complete the applicable replacement form(s) and submit with application. Application and replacement forms(s) must be dated on the same date.** .....  Yes  No
2. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? .....  Yes  No

Insured's Name	Company	Owner	Life Amount	Accidental Death Benefit	Policy Date

**6. HEALTH INFORMATION** (Provide details of all Yes answers in the Health Question Details/Remarks section.)

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

Has the Proposed Insured smoked cigarettes within the last twelve (12) months?.... <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Proposed Insured's Height</b>	<b>Proposed Insured's Weight</b>
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**PART 1** **Yes No**

1. Is the Proposed Insured currently: hospitalized, bedridden, confined to a nursing facility, receiving hospice or home health care; using oxygen to assist in breathing now or within the last six (6) months; confined to a wheelchair or using a walker for a chronic illness now or within the last six (6) months; waiting for or have received an organ transplant; advised to have tests or surgery which have not been completed within the last twelve (12) months; diagnosed with a terminal illness; or paralyzed? .....
2. Has the Proposed Insured ever:
  - 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: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? .....
3. 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)? .....
4. 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)? .....
5. 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? .....
6. 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? .....
7. In the past two (2) years, has the Proposed Insured taken medication for diabetes in combination with a medical history of stroke or TIA, heart disease or disorders, kidney disease, eye problems or any other circulatory disease (any disease that affects the heart and the blood vessels)? .....

**PART 2** **Yes No**

1. In 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? .....
2. In the past three (3) years, has the Proposed Insured experienced complications of diabetes including: amputation, eye or kidney problems, insulin shock, or diabetic coma? .....
3. 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? .....
4. In the past two (2) years, has the Proposed Insured had, been told they have, been treated for, or been prescribed medication for: emphysema, chronic bronchitis that is not seasonal, or any other chronic respiratory or lung problem excluding allergies or asthma? .....

**Eligibility for Ultra Protector I, a level death benefit policy, is based on answers to the Health Questions and additional underwriting criteria.**

**7. HEALTH QUESTION DETAILS/REMARKS** (Attach a separate sheet if more space is needed; additional sheet must be signed and dated by Proposed Insured/Owner to avoid amendments.)

**8. AUTHORIZATION AND ACKNOWLEDGMENT**

I/We authorize any insurance or reinsurance company, employer, 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 the Medical Information Bureau (MIB, Inc.) that has any record of information about me/us or my/our minor children who are to be insured, to give to Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, 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.

Americo may release information obtained by this Authorization to its reinsurers, MIB, Inc., to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required. Although federal regulations require that Americo inform You of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Americo pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years (180 days for HIV-related information) from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf.

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.

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 us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

**REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION:** Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed. Notwithstanding the foregoing, if this application is not solicited face to face and is effected through any electronic means, any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction of the Owner, and said jurisdiction will also be the "Signed at (City and State)" inserted below.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I/WE AGREE THAT ALL ANSWERS TO THE HEALTH QUESTIONS ON PAGE 2 OF THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

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.**

2. How long has the Agent known the Proposed Insured(s)? \_\_\_\_\_ **Yes No**
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 annuity coverage on the life of any Proposed Insured? If Yes, complete the applicable replacement form(s) and submit with application. Application and replacement forms(s) must be dated on the same date. ....
8. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? If Yes, 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 #	%
	Andrew Orlikoff	623-742-3878	andy@freemedquotes.com	62COL05882	

AAA5099-AS (06/11)

Agent's Report

**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 authority is to remain in effect until revoked by me. 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.

I understand that Americo requires a five business day advance notice to set up, change, or discontinue my bank draft information. I understand also that my insurance policy may lapse if said draft is returned unpaid by my Bank or if I discontinue payments prior to receiving confirmation of draft processing from the Company.

**Requested Draft Date:** \_\_\_\_\_ (Note: bank drafts cannot occur on the 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup> of the month) **Unless otherwise requested, premium will be drafted from your account IMMEDIATELY upon policy issuance.**

ACCOUNT INFORMATION	PAYOR INFORMATION (Complete only when Payor is different than Proposed Insured & Owner.)	
<b>Check One:</b> <input type="checkbox"/> Checking Account (include voided check) <input type="checkbox"/> Savings Account (include deposit slip) <input type="checkbox"/> Check with Application (Use the deposit & routing number from the enclosed check in lieu of a voided check.)  <input type="checkbox"/> Check here if the account selected above is a business account.  <b>X</b> _____ Payor's Signature (as it appears on bank records)                      Date	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 or deposit slip here.**

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

**DISCLOSURE STATEMENT FOR ACCELERATED BENEFIT  
PAYMENT RIDER - RIDER SERIES 2146**



**GENERAL DESCRIPTION OF THE ACCELERATED BENEFIT**

AAA8386

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 Insured)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent or Broker's Signature

\_\_\_\_\_  
Date

Mail ---->

### Americo Financial Life and Annuity Insurance Company

Home Office: Dallas, Texas • Administrative Office: P. O. Box 410288, Kansas City, MO 64141-0288

Fax----->

### Faxed Application Transmittal Form

Toll Free Fax Number: (800) 395-9261 (This Fax number is to be used for New Business application purposes only)

**For the best opportunity for successful fax communication with Americo the following standards are suggested:**

- G3 Fax Format Support
- Fax hardware capable of connection speeds equal to or greater than 14.4K
- Dedicated phone line for faxes or one shared with a traditional POTS voice line
- We do not support VoIP at this time (VoIP = Voice Over IP)

### You may fax multiple applications with this form.

If this form is completed and faxed as your cover sheet, we will fax back with confirmation. (Confirmation will be faxed within eight (8) business hours of original receipt.) In order to expedite your receipt of the policy number for this (these) application(s), please enter the most current e-mail address for policy number confirmation should the fax attempt not be successful: andy@freemedquotes.com

**PLEASE NOTE: Applications noted as incomplete require additional items. Please fax these additional items to (800) 395-9261 or contact the Agent Call Center at (800) 634-1180 for assistance.**

**\*\* Be sure to write the appropriate policy number on each item \*\***

PLEASE PRINT LEGIBLY

Agency Name Health Insurance Group of Arizona	Agent Name Andrew Orlikoff
Agent Phone Number 623-742-3878	Agent Code 62COL05882
Fax # to fax confirmation to 623-505-4807	Total Number of Applications Faxed
Total Number of Pages Faxed	

**HOME OFFICE USE ONLY**

Policy Number	Insured's Name	Agent Code	Reason for Incomplete Status
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			