

**AMERICAN INVESTORS LIFE INSURANCE COMPANY**

**P.O. Box 2039, Topeka, Kansas 66601 (800) 435-4884**

<b>PROPOSED INSURED OR ANNUITANT</b>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Date of Birth</b>	<b>State of Birth</b>	<b>Age</b>	<b>Height</b>	<b>Weight</b>
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TO BE COMPLETED BY THE PROPOSED INSURED: To the best of your knowledge and belief: Yes    No

1. a. Have you been gainfully employed (at least 30 hours per week) for the past 12 months? .....  Yes  No
- b. If retired are you capable of such employment? .....  Yes  No
2. To the best of your knowledge and belief, have you been diagnosed, advised to seek treatment, or been treated by a medical practitioner, within the past 10 years for:
  - a. cancer, leukemia or melanoma, organ transplant, systemic lupus, an immune deficiency disorder (AIDS), AIDS Related Complex (ARC), AIDS related conditions, or been advised not to donate blood; or tested positive for antibodies to the AIDS, or human immunodeficiency virus (HIV)? .....  Yes  No
  - b. grand mal epilepsy, Alzheimer's or organic brain disease, psychosis, paralysis, alcohol or drug use, or any disease of the nerves or muscles? .....  Yes  No
  - c. chest pain, heart murmur, heart or vascular surgery, coronary, carotid or peripheral vascular disease, enlarged heart, aneurysm, cardiomyopathy, congestive heart failure, irregular heart beat, elevated blood pressure, or disease of the blood? .....  Yes  No
  - d. tuberculosis, cystic fibrosis, bronchiectasis, or chronic obstructive pulmonary disease or any disease of the blood? .....  Yes  No
  - e. ulcerative colitis, regional enteritis, gastrointestinal hemorrhage, cirrhosis, hepatitis, or pancreatitis? .....  Yes  No
  - f. chronic nephritis or kidney disease, renal failure, or dialysis? .....  Yes  No
  - g. diabetes, rheumatoid arthritis, joint replacement, amputation, or disease of the adrenal or pituitary glands? .....  Yes  No
3. Are you currently under treatment or taking medication? .....  Yes  No
4. To the best of your knowledge have you:
  - a. been advised to have any diagnostic test, hospitalization or surgery not yet completed? .....  Yes  No
  - b. other than above, had any consultation, treatment or hospitalization within the past 5 years? .....  Yes  No
  - c. any doctor's appointments currently scheduled? .....  Yes  No
  - d. ever sought treatment for alcoholism or drug abuse? .....  Yes  No

Give complete details for all questions answered "yes" (except number 1) in the space provided below (attach separate sheet if necessary and be sure it is signed and dated).

Question Number	Date(s) of Treatment	Provide Reason(s) for Consultation(s), name(s), address(es), and phone number(s) of physician(s) and include details of treatment prescribed/result of consultation, medication prescribed.

5. Have you had life or health insurance declined, non-renewed, rated, modified, postponed or cancelled? .....  Yes  No
6. List life insurance, disability income and annuity policies in force on life of proposed insured:

Company	Policy No.	Year Issued	Plan	Amount

**AGREEMENT FOR PURCHASE OF ANNUITY POLICY:** Except as stated above, I believe I am now in good health. I represent that each of the above statements and answers is true and complete to the best of my knowledge and belief. I understand my statements shall be the basis for issue of an annuity policy by American Investors Life Insurance Company, Inc. A copy of this application shall be attached to and made part of the policy. I authorize any licensed physician, medical practitioner or other medical or medically related facility, insurance company, the MIB, Inc. or other organization, institution or person that has any records or knowledge of me or my health to give such information to American Investors Life Insurance Company, Inc. or its reinsurers. This authorization is valid for 30 months and includes information about drugs, alcoholism, or mental illness. I have read and understand the Notice of Shared Medical Information on the attached sheet. A photographic copy of this application shall be as valid as the original.

Signed at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_

Signature of Annuitant \_\_\_\_\_

Signature of Agent \_\_\_\_\_

In the following Notice and Agreement, "We," "Us" and "Our" refer to the  
AMERICAN INVESTORS LIFE INSURANCE COMPANY, INC.

## **NOTICE OF SHARED MEDICAL INFORMATION**

You are undoubtedly aware that when you apply for certain kinds of insurance or credit, the companies involved attempt to verify the information on your application. This is sound business procedure and helps protect both parties.

Information regarding your insurability will be treated as confidential except that We or Our reinsurers may make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies. MIB, Inc. operates as an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, MIB, Inc., will supply the information it may have in its files.

Upon receipt of a request from you, MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB, Inc. Information Office is:

Post Office Box 105  
Essex Station  
Boston, Massachusetts 02112  
Telephone Number: (617) 426-3660

We or Our reinsurers may also release information in Our file to Our reinsurers or to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

**LEAVE WITH ANNUITANT**