Home Office:
5000 Westown Parkway, Ste. 440
Des Moines, IA 50266
Phone 888-221-1234
Fax 515-221-9947
www.american-equity.com

Life Insurance Application

American Equity Investment Life Insurance Company

Life Division: 20 Cropwell Drive, Ste. 100
Pell City, AL 35128
Phone 877-508-9888
Fax 205-884-7928

APPLICANT

Name_______________ Sex_______

Birth date ___/___/___ Soc. Sec. No._______________

Birth Place_______________ Height_____ Weight______

Address_______________ Phone__________

City_______________ State_____ Zip__________

SPOUSE

Name_______________ Sex_______

Birth date ___/___/___ Soc. Sec. No._______________

Birth Place_______________ Height_____ Weight_____

CHILDREN

Date Of Birth Of Oldest Child Under 18 (or age)__________

BENEFICIARY-The applicant is the beneficiary and owner of the spouse policy and any children's rider(s), unless endorsed otherwise.

Name_______________ Relationship: _______________

Name_______________ Relationship: _______________

Policy form:_______________ Premiums:__________ ☐ Monthly ☐ Bi-Weekly ☐ Other__________

Face Amount: Self $__________ Spouse $__________ Dependent Children $__________

If available, I request the automatic premium loan provision on the above policy(ies) ☐ Yes ☐ No

IN THE PAST THREE YEARS HAS ANY PROPOSED INSURED HAD ANY, BEEN DIAGNOSED AS HAVING, OR RECEIVED MEDICAL OR SURGICAL TREATMENT FOR ANY OF THE FOLLOWING?

1. Have any impairments in health or physical condition?* ☐ Yes ☐ No
2. Had any illness or injuries?* ☐ Yes ☐ No
3. Cancer, Diabetes, Disease of the Heart, Lungs, Stomach, Kidney, Liver; Brain or any other disease?* ☐ Yes ☐ No
4. Have or had Alcoholism, Drug addiction, Substance abuse? ☐ Yes ☐ No
5. Mental or Nervous Disorder? ☐ Yes ☐ No
6. Currently take Prescription Drugs? ☐ Yes ☐ No

* AIDS, ARC or HIV must be diagnosed by a member of the medical profession, doctor or a physician.

Ever been refused, postponed or rated up by an insurance company? ☐ Yes ☐ No

IF THE ANSWER FOR ANY POTENTIAL INSURED IS YES TO ANY OF THE ABOVE QUESTIONS, COMPLETE REVERSE SIDE OF THIS FORM.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having available information about diagnosis, treatment and/or prognosis of me or of any member of my family pertaining to any physical or mental condition, including alcoholism and/or use of drugs, and any other non-medical information about me or my family to give the Company or it's reinsurers any and all such information.

 NOTE: **Make all Checks payable to American Equity Investment Life Insurance Company**

IF THE ANSWER FOR ANY POTENTIAL INSURED IS YES TO ANY OF THE QUESTIONS ON THE FACE OF THIS FORM, INDICATE BELOW, WHICH INSURED, THE NATURE, DURATION AND SEVERITY OF THE ILLNESS OR INJURY. GIVE DATES AND DETAILS, PROVIDE THE NAME AND ADDRESS OF THE PHYSICIAN. THE DATE AND NAME OF THE INSURANCE COMPANY AND REASON FOR REFUSAL, POSTPONEMENT OR RATING.

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Will this policy replace any life insurance or annuity with this or any other company? ❒ Yes ❒ No
(If "YES", please provide details and all required replacement forms.)

Insured____________________ Company__________________________ Plan______________

Amount____________ Reason____

Each person who signs below acknowledges that he/she has read and understands this Application and has read and understands the Information Practices outlined on the back of this form.

Do you have knowledge or reason to believe that replacement of existing insurance may be involved? ❒ Yes ❒ No

____
Agent's Name/Number (Please Print)

____
Agent's Signature/Phone Number

____
Resident's Agent's Countersignature/Phone Number (where required)

To the best of my knowledge and belief, the statements above are true and complete.

Signed at______________________ on_____/_____/_____
City/State Date

____
Applicant's Signature

____
Other Proposed Insured(s) Signature

5001

DETACH AND LEAVE WITH APPLICANT

INFORMATION PRACTICES

FAIR CREDIT REPORTING ACT NOTICE

I (We) understand, as part of the normal procedure of processing an application, The Company may obtain an investigative consumer report concerning such information as character, general reputation, personal characteristics such as health, finances, job, through personal interviews with friends, neighbors, and associates. We may request further information on the nature and scope of any such report, by requesting it in writing from The Company.

APPLICANT'S PRE-NOTICE

The Company treats information regarding your insurability as confidential. The Company or its reinsurers may, however, make a brief report based on this information to the Medical Information Bureau, 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 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, MA 02112, telephone number (617) 426-3660. The Company or its reinsurers may also release information in its file 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.