APPLICATION FOR INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO., * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

FLORIDA

Requested Effective Date (mm-dd-yyyy) __ __ - __ __ - 2 0 __ __

Payment Mode
○ Monthly ○ Semi-Annual
○ Quarterly ○ Annually

Payment Type
○ Bank Draft
○ Direct

Draft Day (01 to 28 only) __ __

○ **Primary Insured**

LIFE Plans: ○ **10 Year Renewable Term** ○ **20 Year Term to ART** ○ **10 Year Term to ART**

Life Face Amount $ ___,___ Premium (including riders) $ _,___.__

Optional Riders
Child Term Rider ○ $5,000 ○ $10,000
Accident Benefit Rider ○ $25,000 ○ $50,000 ○ $75,000 ○ $100,000
○ **Waiver of Premium Rider**

○ **Spouse**

LIFE Plans: ○ **10 Year Renewable Term** ○ **20 Year Term to ART** ○ **10 Year Term to ART**

Life Face Amount $ ___,___ Premium (including riders) $ _,___.__

Optional Riders
Child Term Rider ○ $5,000 ○ $10,000
Accident Benefit Rider ○ $25,000 ○ $50,000 ○ $75,000 ○ $100,000
○ **Waiver of Premium Rider**

○ **Child 1**
LIFE Plans: ○ **10 Year Renewable Term**
Life Face Amount $ ___,___ Premium $ _,___.__

○ **Child 2**
LIFE Plans: ○ **10 Year Renewable Term**
Life Face Amount $ ___,___ Premium $ _,___.__

○ **Child 3**
LIFE Plans: ○ **10 Year Renewable Term**
Life Face Amount $ ___,___ Premium $ _,___.__

Best time to call: ○ 8 AM - Noon ○ Noon - 6 PM ○ 6 PM - 9 PM

Home Phone No. ___ - ___ - ____

Work Phone No. ___ - ___ - ____

Total Premium $ _,___.__

Total Collected with Application $ __,___.__

Applicant if other than Primary Insured/Owner

Name: ______________________ Relationship to Primary Insured: ______________

Address: ______________________ City: ____________ State: _____ ZIP: __________

Is Applicant to be Owner of all Policies? *If "No", Owner shall be Primary Insured.* ○ **Yes** ○ **No**

Primary Insured (or Owner if Application is for Children's Insurance Only)

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced

First Name ____________________ M.I. __ Height (ft. in.) __ __

Last Name ____________________ ○ Male ○ Female Weight (lbs.) ___

Address ________________________________

City ______________ State __ Zip Code _____ Age __

Birth State __ Date of Birth (mm-dd-yyyy) __ - __ - ____ SS # ___ - __ - ____

Driver's Lic. Issue State __ Driver's Lic. Number ____________________

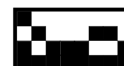
Primary Insured's Occupation ______________ Employer's Name ______________

Primary Insured's E-mail Address: ______________

I, the agent, have personally seen this person: ○ **Yes** ○ **No**

(Application Continued)
UAI0394 0114

40290



ILAP(09)

Spouse First Name | M.I. | Height (ft. in.)

Last Name | ○ Male ○ Female | Weight (lbs.)

Age | Birth State | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Driver's Lic. Issue State | Driver's Lic. Number

Spouse's Occupation | Employer's Name

Child 1 First Name | M.I. | Height (ft. in.)

Last Name | ○ Male ○ Female | Weight (lbs.)

Age | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Driver's Lic. Issue State | Driver's Lic. Number

Child 2 First Name | M.I. | Height (ft. in.)

Last Name | ○ Male ○ Female | Weight (lbs.)

Age | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Driver's Lic. Issue State | Driver's Lic. Number

Child 3 First Name | M.I. | Height (ft. in.)

Last Name | ○ Male ○ Female | Weight (lbs.)

Age | Date of Birth (mm-dd-yyyy) - - | I, the agent, have personally seen this person. ○ **Yes** ○ **No**

Driver's Lic. Issue State | Driver's Lic. Number

	PRIMARY INSURED **YES/NO**	SPOUSE **YES/NO**	CHILD 1 **YES/NO**	CHILD 2 **YES/NO**	CHILD 3 **YES/NO**
1. Has any Proposed Insured ever been treated by a licensed member of the medical profession consulted by the applicant for any of the following conditions:					
a. High blood pressure, chest pain, heart attack, stroke or any heart or circulatory disorder?	○ ○	○ ○	○ ○	○ ○	○ ○
b. Asthma, emphysema, or other respiratory disorder?	○ ○	○ ○	○ ○	○ ○	○ ○
c. Ulcer, colitis, or other digestive tract disorder?	○ ○	○ ○	○ ○	○ ○	○ ○
d. Cirrhosis, hepatitis, or other liver disorder, or blood disorder?	○ ○	○ ○	○ ○	○ ○	○ ○
e. Diabetes or other endocrine disorder?	○ ○	○ ○	○ ○	○ ○	○ ○
f. Kidney, prostate, urinary bladder or other genitourinary disorder?	○ ○	○ ○	○ ○	○ ○	○ ○
g. Paralysis, epilepsy, mental disease or disorder or any other nervous system or brain disorder?	○ ○	○ ○	○ ○	○ ○	○ ○
h. Cancer, tumor, or unexplained masses?	○ ○	○ ○	○ ○	○ ○	○ ○
i. Disease of the breasts, uterus or ovaries?	○ ○	○ ○	○ ○	○ ○	○ ○
j. Rheumatoid arthritis or any other musculoskeletal disorder?	○ ○	○ ○	○ ○	○ ○	○ ○

(Application Continued)

		PRIMARY INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
2.	Has any Proposed Insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	○○	○○	○○	○○	○○
3.	Has any Proposed Insured in the last 5 years:					
	a. Had a physical examination?	○○	○○	○○	○○	○○
	b. Had any medical treatment? (includes prescription medications)	○○	○○	○○	○○	○○
	c. Been hospitalized?	○○	○○	○○	○○	○○
4.	Has any Proposed Insured ever been treated or advised to be treated by a licensed member of the medical profession consulted by the applicant for alcoholism or alcohol abuse including membership in A.A., or been advised by a licensed member of the medical profession consulted by the applicant to reduce alcohol consumption?	○○	○○	○○	○○	○○
5.	Has any Proposed Insured ever used narcotics, sedatives or hallucinogens?	○○	○○	○○	○○	○○
6.	Has any Proposed Insured used marijuana in the past year?	○○	○○	○○	○○	○○

Important - Details of "Yes" answers to questions 1 thru 6

* In column below list "**I** " for Insured, "**S**" for Spouse, "**C1**" for Child 1, "**C2**" for Child 2 and "**C3**" for Child 3.

*	Question No.	Name, Address and Telephone No. of Each Physician Practitioner and/or Health Facility	Dates and Durations	Name and Severity of Condition, Frequency of Attacks, Specific Diagnosis and Treatment

		PRIMARY INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
7.	Has any Proposed Insured ever been arrested, including arrests for driving while intoxicated, or under the influence?	○○	○○	○○	○○	○○
8.	Has any Proposed Insured:					
	a. Used tobacco in any form within the past 12 months?	○○	○○	○○	○○	○○
	b. Ever used tobacco? If "Yes" give date of last use, frequency and amount used:	○○	○○	○○	○○	○○

Date (mm-dd-yyyy) [ ][ ] - [ ][ ] - [ ][ ][ ][ ]   Frequency and Amount [ ]

9. **Supplemental Questions 9a through 9d if Face Amount Applied for is $100,000 or Greater:**

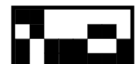
a. Total life insurance in force: **$**

		PRIMARY INSURED YES/NO	SPOUSE YES/NO	CHILD 1 YES/NO	CHILD 2 YES/NO	CHILD 3 YES/NO
b.	Has the Proposed Insured within the last 2 years made or intended to make any flights other than as a passenger on a scheduled airline?	○○	○○	○○	○○	○○
c.	Has the Proposed Insured within the last 2 years engaged in or intended to engage in automobile, motorboat, or motorcycle racing, scuba, skin, or sky diving?	○○	○○	○○	○○	○○
10.	Is any Proposed Insured a non-citizen of the United States?	○○	○○	○○	○○	○○
11.	Is the insurance applied for intended to replace or change any insurance or annuities with this or any other company?	○○	○○	○○	○○	○○
12.	Has any Proposed Insured ever been rejected for life insurance, rated, or failed to receive a policy as applied for?	○○	○○	○○	○○	○○

Please provide the primary personal physician details below for each Proposed Insured

* In column below list "**I** " for Insured, "**S**" for Spouse, "**C1**" for Child 1, "**C2**" for Child 2 and "**C3**" for Child 3.

*	Name, Address and Telephone No. of Each Physician Practitioner and/or Health Facility	Date Last Seen



APPLICATION FOR INSURANCE * UNITED AMERICAN INSURANCE COMPANY
A LEGAL RESERVE STOCK CO., * ADMINISTRATIVE OFFICE: MCKINNEY, TX 75070

FLORIDA

Primary Insured's Beneficiary | Beneficiary Relationship

Beneficiary for Spouse and/or Children will be Primary Insured (owner) *unless notice is given to United American Insurance Company's Home Office.*

AGREEMENT: Florida applicants have the right to designate a secondary addressee, instructions will accompany all Florida policies at issue. I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full and complete and true to the best of my knowledge and belief and shall be considered to be representations and not warranties. The answers are to be the basis of any insurance issued. No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final application acceptance is made by the Underwriting Department of the Company.

I, HEREBY AUTHORIZE the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that I or an authorized representative may request a copy of this authorization. Information for consumers MIB , Inc. may be obtained on its website at www.mib.com.

Personal information may be collected from other parties. Such information, and other personal or privileged information later collected, may be disclosed to third parties without authorization. You have the right to access and correction with respect to all personal information collected, and a full notice of your rights will be furnished upon request.

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.

To the best of your knowledge as writing agent, is the insurance applied for intended to replace any existing insurance? ○ **Yes** ○ **No**
If "YES", complete a replacement form.
I certify I have personally seen the applicant and accurately recorded the information supplied by the applicant.

Date Application Signed (mm-dd-yyyy) __ __ - __ __ - __ __ __ __

City ________ State __

Agent's Signature

Agent's Complete First and Last Name PRINTED

Agent's Florida License ID No.

Last Name _____ Agent No. ______

Print First 5 Letters of Agent's Last Name

Signed **Primary Insured**

Signed **Applicant (If other than the Primary Insured)**

Signed **Spouse**

Signed **Child's Signature (If over the age of 18)**

SEND POLICY TO: ○ Agent ○ Insured

ILAP(09)

(The Policy will be sent to Insured unless otherwise instructed.)

"Automatic" Payment Plan / Bank Draft

Please **TAPE** personalized **VOIDED CHECK** here.
DO NOT STAPLE

"AUTOMATIC" PAYMENT PLAN / BANK DRAFT AUTHORIZATION: I authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of United American Insurance Company. This authorization is to remain in effect until revoked by me. All premiums and non-insurance charges may be automatically withdrawn from my account on **MONTHLY** mode, *unless a different mode has been selected on page one of the application.*

40290

Account Holder's Signature (as it appears on financial institution records)