TEXAS

Our **Juvenile Whole Life Insurance Policy** is All About Helping You Leave a Legacy!

United American Insurance Company
Since 1947

Your grandchildren bring you joy and remind you of life's most precious moments — that first smile, first word, and first step.

As your grandchildren grow up and begin to experience the world around them, life's living expenses become a reality.

United American's Juvenile Whole Life insurance policy may be able to help your family prepare for the unexpected and help provide financial protection that can last a lifetime.

UAI3962

UAI3178(42) **0421**

UA's Juvenile Whole Life Insurance Policy Offers Low Childhood Rates to Fit Your Budget.

For just pennies a day, you may be able to help protect your grandchild's financial future with whole life insurance benefit amounts ranging from $1,000 – $25,000[1].

The best time to purchase insurance is when they're young. Why? Because the premiums are as low as they're ever going to be. You can lock in a low premium rate now that will never increase[2].

If you're like most grandparents, you often give your grandchildren gifts ... but, how many of those gifts can last a lifetime?

UA's Juvenile Whole Life Insurance Policy Offers Many Financial Advantages:

- Juvenile Whole Life insurance provides permanent lifetime coverage[3]
- Cash value and loan value accumulate as the child grows[4]
- Paid up insurance and extended term insurance that may provide options for the future
- Coverage can stay with child through adulthood, regardless of changes in health or occupation

[1] Example based on a face amount of $25,000 for a female, age 5, with a monthly premium of $7.42 in FL. This amounts to $0.27 using a 28-day billing calendar. Your actual policyholder premium may vary and is subject to underwriting. Benefit amounts range from $5,000 - $25,000 in WA.

[2] Policy premium is based on age and is usually lower for younger ages.

[3] As long as premiums are paid on time.

[4] Cash and loan benefits can only be accessed by the policyholder. In order for the insured child to access cash or loan benefits when the child becomes of age, policy ownership must be transferred to insured child.

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

Requested Effective Date (mm-dd-yyyy)

☐☐ - ☐☐ - 20☐☐

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

Payment Type ○ Bank Draft ○ Direct

Draft Day (01 to 28 only) ☐☐

LIFE PLAN

		Life Face Amount	Premium
○ **Child 1**	○ **Whole Life**	$ ☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
○ **Child 2**	○ **Whole Life**	$ ☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
○ **Child 3**	○ **Whole Life**	$ ☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
○ **Child 4**	○ **Whole Life**	$ ☐☐,☐☐☐	$ ☐,☐☐☐.☐☐
○ **Child 5**	○ **Whole Life**	$ ☐☐,☐☐☐	$ ☐,☐☐☐.☐☐

Total Premium $ ☐,☐☐☐.☐☐

Total Collected with Application $ ☐☐,☐☐☐.☐☐

Applicant if other than Owner

Name: _____ Relationship to Owner: _____

Address: _____ City: _____ State: _____ ZIP: _____

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

Home Phone No. ☐☐☐ - ☐☐☐ - ☐☐☐☐

Work Phone No. ☐☐☐ - ☐☐☐ - ☐☐☐☐

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

Owner of Children's Insurance

First Name | M.I. | ○ Male ○ Female

Last Name

Address

City | State | Zip Code | Age

Birth State | Date of Birth (mm-dd-yyyy) | SS #

E-mail Address

Relationship of Owner to Children

Beneficiary for Children will be Owner (*unless notice is given to United American Insurance Company's Home Office).*

Child 1
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) | SS #

Child 2
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) | SS #

Child 3
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) | SS #

Child 4
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) | SS #

Child 5
First Name | M.I. | ○ Male ○ Female | Height (ft. in.) | Weight (lbs.)

Last Name

Age | Date of Birth (mm-dd-yyyy) | SS #

ALL LIFE INSURANCE APPLICANTS MUST ANSWER ALL THE FOLLOWING QUESTIONS.	CHILD 1 **YES/NO**	CHILD 2 **YES/NO**	CHILD 3 **YES/NO**	CHILD 4 **YES/NO**	CHILD 5 **YES/NO**
1. Are all Children proposed to be insured permanent residents of the United States or Canada?	○ ○	○ ○	○ ○	○ ○	○ ○
2. Do you have complete knowledge of the health information of all Children proposed to be insured?	○ ○	○ ○	○ ○	○ ○	○ ○
3. Do any Children proposed to be insured have existing (or pending applications for) life insurance or annuity contracts in force? If yes, list coverage type _____	○ ○	○ ○	○ ○	○ ○	○ ○
4. Will the life insurance being applied for replace or change any existing life insurance? (If "Yes," complete a Replacement Form).	○ ○	○ ○	○ ○	○ ○	○ ○
IF THE ANSWER IS "YES" TO ANY ONE OF QUESTIONS 5-7 BELOW FOR ANY CHILD, THEN THAT CHILD IS NOT ELIGIBLE FOR COVERAGE.					
5. Has any Child proposed to be insured in the past **12 MONTHS,**					
a. been administered oxygen or confined for 24 hours or more to a hospital, neonatal ICU, or psychiatric facility excluding confinements for: normal childbirth, normal neonatal care, and conditions for which the proposed insured has completely recovered?	○ ○	○ ○	○ ○	○ ○	○ ○
b. been advised by a medical professional to have a diagnostic test (excluding HIV and AIDS) or surgery that has not been performed or for which results have not been received?	○ ○	○ ○	○ ○	○ ○	○ ○
c. had uncontrolled epilepsy or more than 2 seizures for any reason?	○ ○	○ ○	○ ○	○ ○	○ ○
d. been convicted of operating a vehicle while under the influence of drugs or alcohol, been convicted of reckless driving, or had a suspended or revoked driver's license?	○ ○	○ ○	○ ○	○ ○	○ ○
6. Has any Child proposed to be insured in the past **10 YEARS** been diagnosed with, treated for, or taken prescription drugs for any of the following:					
a. Cancer in any form including leukemia, lymphoma, osteosarcoma, and Hodgkin's disease?	○ ○	○ ○	○ ○	○ ○	○ ○
b. Heart disease, heart surgery, stroke, transient ischemic attack (TIA), mini-stroke, or uncontrolled high blood pressure?	○ ○	○ ○	○ ○	○ ○	○ ○
c. Multiple sclerosis, muscular dystrophy, or systemic lupus?	○ ○	○ ○	○ ○	○ ○	○ ○
d. Kidney disease, liver disease, chronic hepatitis, hepatitis C, insulin dependent diabetes, or sickle cell anemia?	○ ○	○ ○	○ ○	○ ○	○ ○
e. Depression, bipolar disorder, alcohol or drug abuse, spina bifida, or any surgery or injury to the brain or spinal cord from which the Child has not fully recovered?	○ ○	○ ○	○ ○	○ ○	○ ○
7. Has any Child proposed to be insured **EVER,**					
a. been diagnosed with any immune deficiency including AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?	○ ○	○ ○	○ ○	○ ○	○ ○
b. had or been advised by a medical professional to have an organ or tissue transplant; of having any illness indicated as being terminal; or of having a life expectancy of 10 years or less?	○ ○	○ ○	○ ○	○ ○	○ ○
c. been diagnosed with Down Syndrome or a Chromosomal Disorder?	○ ○	○ ○	○ ○	○ ○	○ ○

AGREEMENT: I hereby apply to United American Insurance Company for a policy to be issued solely and entirely in reliance upon the written answers to the foregoing questions, and I expressly agree on behalf of myself and any person who shall claim any interest in any policy issued on this application as follows: (1) All statements and answers contained herein are full, complete and true to the best of my knowledge and belief. (2) The insurance hereby applied for shall not be considered in force until a policy is issued and delivered to me and the full first premium paid thereon while the Proposed Insured's health and other conditions remain as described in this application.

I hereby authorize MIB, Inc. ("MIB"), any insurance company, hospital, physician, or other practitioner that possesses any records of me or my physical or mental health and/or treatment, to give any and all such information to United American Insurance Company ("UA") for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize UA, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization shall be valid for two years from this date and may be revoked by sending written notice to UA. I understand that I or my authorized representative may request a copy of this authorization from UA or request a copy of the information in MIB's files by writing to MIB at MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or calling (866) 692-6901. I acknowledge receipt of the MIB Pre-Notice. A photographic copy of this authorization will be as valid as the original.

Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to criminal and civil penalties.

To the best of your knowledge as writing agent, is the insurance applied for intended to replace any existing insurance? ○ **Yes** ○ **No**

I certify I have personally seen the applicant/child(ren). ○ **Yes** ○ **No**

I certify that I have accurately recorded the information supplied by the applicant.

Date Application Signed (mm-dd-yyyy) ☐☐ – ☐☐ – ☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐

Signed _____

Agent's Signature

Owner

Last Name ☐☐☐☐☐ Agent No. ☐☐☐☐☐☐

Print First 5 Letters of Agent's Last Name

Signed _____

Applicant (If other than the Owner)

SEND POLICY TO: ○ Agent ○ Insured

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

Signed _____

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

Signed _____

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

JUV14(42)

United American Insurance Company
Since 1947

Bank Draft Authorization

Draft date cannot be the 29th, 30th or 31st.

Proposed Insured's Social Security Number

			-			-				

Requested Bank Draft Day (dd)

Payor's First Name

																			M.I.

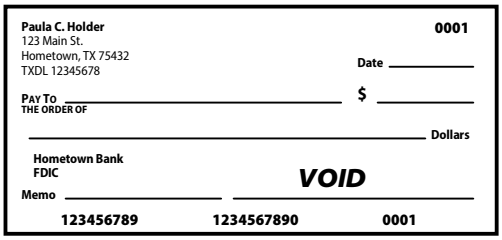
Payor's Last Name

Bank ABA Routing Number

Account Number

Bank Name

Account information fields above must be complete if voided check is not attached.
See the example check below for the location of the Bank Routing Number and Account Number.



Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

As a convenience to me, I hereby request and authorize you, United American Insurance Company, McKinney, Texas, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

NOTE - <u>Business</u> accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (SP 9-01) are required.

Payor's Signature (as it appears on bank records)

FORM 1080-C

48656

UAI1756 **0615**

UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

_____ _____

Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application(s) for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, UA may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Home Office Copy

Life Insurance Packet
Applicant Acknowledgement

United American Insurance Company
Since 1947

Thank you for your application.

By signing below you acknowledge that you have received, read and understood the information and notices listed below. Keep your copies with your policy. Contact your Agent or a live insurance specialist at UnitedAmerican.com with any questions.

Notices:

- ☑ Pre-MIB Notice (Medical Information Bureau)
- ☑ Terminal Illness Accelerated Death Benefit Rider Disclosure
- ☑ HIPAA Authorization for Release of Health-Related Information (F3978)

Signature of proposed insured/applicant _____ Date _____

Signature of proposed insured (if other than applicant) _____ Date _____

Signature of proposed insured (if other than applicant) _____ Date _____

Signature of proposed insured (if other than applicant) _____ Date _____

Writing Agent Name (please print) _____ Writing Agent Signature _____ Writing Agent # _____

United American Insurance Company
Since 1947

FAX

To: New Business Department
Primary Fax: 972-767-4462
Secondary Fax: 972-569-3678
From:

United American Insurance Company
Attn: New Business
P.O. Box 8080
McKinney, TX 75070

Date

Agent Name

Agent No.

Agent Phone

# of Pages

Applicant Name

The attached documents are for Final Expense Whole Life application processing.

Comments

Important:

- **If premium is collected or a voided check provided, application must be mailed.**
- **Remember to include Bank Draft authorization.**
- **Do not fax applications that have been mailed.**
- **Send only one application per fax.**
- **Send fax to only one phone number.**
- **A Replacement Form is required when a replacement occurs. Check the UA Compliance Sheet for requirments.**
- **Applications for life products will not be processed without required forms completed.**

 UAI3126 **0416**

United American Insurance Company
Since 1947

P.O. Box 8080 • McKinney, Texas 75070
www.unitedamerican.com

MIB, Inc., Pre-Notice

Information regarding your insurability will be treated as confidential. United American Insurance Company, or its reinsurers may, however, make a brief report theron to the MIB, Inc., formerly known as the Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

United American Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE TO ALL LIFE INSURANCE APPLICANTS

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER DISCLOSURE

Not available in: CT, NJ, SC, VT, WA or WV.

If you applied for a contract that contains a Terminal Illness Accelerated Benefit rider, we are required to provide you with this disclosure and obtain your signature, acknowledging your receipt and review of this document.

The Terminal Illness Accelerated Benefit rider allows the Insured to receive a portion of the contract's Death Benefit upon our receiving due proof that the Insured has a Terminal Illness.

DEFINITION OF TERMINAL ILLNESS:

The Insured has been diagnosed with a noncorrectable medical condition that, with reasonable medical certainty, will result in the Insured's death within twelve (12) months from the date on which this benefit is requested.

AMOUNT OF BENEFIT:

The amount of the Accelerated Benefit will be equal to 50% of the Death Benefit less 50% of any outstanding policy loan and loan interest.

"SAMPLE ILLUSTRATION:"

The calculation of the Accelerated Benefit Amount and the effects on the remaining contract values are shown in the "sample illustration" below:

Contract Death Benefit:				$10,000	
Cash Value:				5,000	
Policy Loan:				2,500	
Accelerated Benefit Amount Calculation:					
$10,000	×	0.50	=	$5,000	Gross Amount
2,500	×	0.50	=	- 1,250	Policy Loan
				$3,750	Amount Payable
Contract Values After Accelerated Benefit Payment:					
$10,000	–	$5,000	=	$5,000	Death Benefit
5,000	–	(0.50 × 5,000)	=	2,500	Cash Value
2,500	–	1,250	=	1,250	Policy Loan

THIS FORM IS NOT A CONTRACT.

It is intended only as a summary of the rider provisions shown. In all cases, consult your rider for full details and restrictions.
Any Accelerated Benefit paid under this contract may be taxable. A personal tax advisor should be consulted.
Payment of any Accelerated Benefit may also adversely affect the recipient's eligibility for Medicaid and other government benefits or entitlement.

Special information for TEXAS RESIDENTS:
The acceleration of life insurance benefits offered under this rider are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the acceleration of life insurance benefits qualify for such favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. Tax laws relating to acceleration of life insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration of life insurance benefits excludable from income under federal law.
Receipt of acceleration of life insurance benefits may affect you, your spouse or your family's eligibility for public assistance programs such as medial assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse or your family's eligibility for public assistance.

_____ _____
Signature of Proposed Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

UNITED AMERICAN INSURANCE COMPANY

3700 S. Stonebridge Drive • McKinney, Texas 75070

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_____ _____

Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the United American Insurance Company (UA) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that UA may: 1) underwrite my application(s) for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UA.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to UA to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization, and that, to the extent that UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent UA from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, UA may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Applicant Copy

Life Insurance Packet
Applicant Acknowledgement

United American Insurance Company
Since 1947

Thank you for your application.

By signing below you acknowledge that you have received, read and understood the information and notices listed below. Keep your copies with your policy. Contact your Agent or a live insurance specialist at UnitedAmerican.com with any questions.

Notices:

- ☑ Pre-MIB Notice (Medical Information Bureau)
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- ☑ HIPAA Authorization for Release of Health-Related Information (F3978)

Signature of proposed insured/applicant	Date
Signature of proposed insured (if other than applicant)	Date
Signature of proposed insured (if other than applicant)	Date
Signature of proposed insured (if other than applicant)	Date

Writing Agent Name (please print)	Writing Agent Signature	Writing Agent #

The Unexpected Can Happen.

Understandably, this can make families anxious about purchasing life insurance for children. However, the coverage provides so much more than just a death benefit. Most families would agree being prepared now can avoid a great deal of hardship and heartache in the future if dealing with unexpected financial burdens.

It's a legacy: The cash value that accumulates in this policy could be presented as a gift to your child or grandchild in the future.

Protecting Your Grandchild's Future is Easy!

- Available for ages 0-18
- Simply answer a few application health questions about your grandchild — no need to provide health records, and no medical exam required for child
- Up to five children can be included on one application, but you will receive an individual policy for each covered child[1]
- You own the policy — no burden on child's parents to pay premiums[2]
- Signature of parents or the insured child is not required on the application (if below the age of majority)[3]

[1] Subject to underwriting approval

[2] In the event of policyholder death, policy may cancel if premiums are not paid and a joint owner is not designated. Refer to your policy for specific guidelines on transfer of ownership.

[3] Unless required by law

Policy Features:

- Benefit amounts ranging from $1,000 – $25,000
- Paid up insurance values
- Extended term insurance
- Cost never goes up
- Coverage never goes down

Stability and Financial Strength

United American Insurance Company has been in the life and supplemental health insurance business since 1947.

For more than 40 consecutive years, United American has earned the A+ (Superior) financial strength rating from A.M. Best Company (as of 7/19), and an AA- (Very Strong) financial strength rating from Standard & Poor's (as of 8/19).

Premium Worksheet*

	Benefit Amounts		
Child Name, Age	$	$	$
Monthly Premium			

* For illustration purposes only. Rates subject to change. Issued policy form rates and terms control.

Make checks payable to UNITED AMERICAN INSURANCE COMPANY, not to an individual.

Received of _____

the sum of $ ____ for _____ month(s) premium, other policy fees and noninsurance charges with application for life insurance.

If for any reason the policy is not issued, payment is to be refunded in full. Insurance is not effective until the policy applied for has been issued, the initial premium paid, and the proposed insured's health and other conditions remain as described in the application.

_____
Date

_____
Agent's Signature

This brochure highlights the features of policy form SWL and rider form ABR1 (where state approved). Policy described herein is not a preneed or prearranged funeral plan. Policy has some limitations and exclusions. Refer to your policy for actual coverage, benefit amounts, and terms. Plan, issue ages, and benefits may vary by state. Child must qualify for coverage amount applicant applies for based on child's age and health. This is a solicitation for insurance. You may be contacted by a state-licensed insurance Agent representing United American Insurance Company.