Eagle Premier Series TeleApp Worksheet

For use in all states except CA, CT, FL, NY, PA, and VT.

This worksheet is to be used to collect information prior to contacting Americo's Call Center. Once completed, call the toll-free number at 855.248.8327. All participants (Agent, Proposed Insured, Owner, and Payor) must be on the phone at the time of the call. All calls are recorded.

This worksheet contains sensitive information and should be kept in a secure location for your records or destroyed.

Agent Information

Name:_____ Agent ID #:_____

Proposed Insured Information

Issue State:_____ Date of Birth: _____/ _____/ _____ ☐ Male ☐ Female

Name *(First, MI, Last)*: _____

Mailing Address: _____

Street Address *(If Mailing Address is a PO BOX)*: _____

If less than 5 years at current address, list prior address: _____

Phone Number: _____-_____- _____ SSN or Taypayer ID: _____

Place of Birth *(City, State, Country)*: _____

Owner Information *(If different than the Proposed Insured)*

Name *(First, MI, Last)*: _____

Relationship to Proposed Insured:_____ SSN or Taypayer ID: _____

Mailing Address: _____

Street Address *(If Mailing Address is a PO BOX)*: _____

Beneficiary Information *(% of Share must total 100%. If shares are not given, they will be equal.)*

☐ Primary ☐ Contingent % of Share: _____ Name *(First, MI, Last)*: _____

Date of Birth: _____/ _____/ _____ Phone Number: _____-_____- _____

Relationship to Proposed Insured:_____

☐ Primary ☐ Contingent % of Share: _____ Name *(First, MI, Last)*: _____

Date of Birth: _____/ _____/ _____ Phone Number: _____-_____- _____

Relationship to Proposed Insured:_____

Product Information *(Not all products are available in all states. See Product Availability Guide for state availability.)*

☐ Level ☐ Guaranteed Face Amount $_____ Effective Date *(If Not Current Date)*: _____/ _____/ _____

Monthly Premium $_____ ☐ Automatic Premium Loan

If applying for Eagle Premier Level, complete the following information:

1. ☐ Cigarette Smoker ☐ Non-Smoker 2. Height _____' _____" 3. Weight _____ (in pounds)

Payor Information *(Complete only when the Payor is different than the Proposed Insured and Owner.)*

Name *(First, MI, Last)*: _____ Relationship to Proposed Insured: _____

Mailing Address: _____

Street Address *(If Mailing Address is a PO BOX)*: _____

Bank Information

Name of Financial Institution: _____

☐ Checking ☐ Savings Routing Number:_____ Account Number:_____

Notes:

Policy Number *(Will be provided at the end of the call.)* ☐☐☐☐☐☐☐☐☐☐

For agent use only. Not for public use.

AMERICO

For reference only. Do not return to Americo.

REPLACEMENT INFORMATION

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? ☐ Yes ☐ No
   If **Yes**, provide information in the table below and answer question 2. If **No**, skip question 2, and proceed to the next applicable section.

Proposed Insured's Name *(Last, First, Middle Initial)*	Company	Owner *(Last, First, Middle Initial)*	Amount	Accidental Death Benefit	Policy Date

2. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? ☐ Yes ☐ No
   Complete the replacement form(s) in accordance with applicable state replacement regulations. Replacement forms must be submitted with the application.

PROPOSED INSURED HEALTH INFORMATION

1. Have You smoked cigarettes within the last twelve (12) months? ☐ **Yes** ☐ **No**

2. Height:

3. Weight:

	Yes	**No**
4. Have You ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a member of the medical profession for:		
a. Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's disease)?	☐	☐
b. Congestive heart failure or cardiomyopathy, chronic kidney disease or kidney failure, or received kidney dialysis?	☐	☐
c. Cirrhosis of the liver, liver failure or other liver diseases (excluding Hepatitis A, B, or C)?	☐	☐
d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic respiratory or lung problem, excluding allergies or asthma?	☐	☐
e. Metastatic cancer (cancer that has spread to other parts of the body)?	☐	☐
f. Two (2) or more occurrences of cancer of any kind or a reoccurrence of a previous cancer?	☐	☐
g. AIDS, ARC, or HIV?	☐	☐
5. In the past twenty-four (24) months, have You been diagnosed, treated, tested positive, or been given medical advice by a member of the medical profession for:		
a. Internal cancer or malignant melanoma (not basal cell skin cancer)?	☐	☐
b. Complications of diabetes, including amputation, retinopathy (eye disease), nephropathy (kidney disease), neuropathy, insulin shock, or diabetic coma?	☐	☐
c. Chronic hepatitis or alcoholic hepatitis?	☐	☐
6. In the past twenty-four (24) months, have You received a diagnosis, been treated, received medical treatment or counseling, or been prescribed medication by a member of the medical profession for drug or alcohol abuse/dependency or addiction?	☐	☐
7. Within the last twelve (12) months, have You been advised to have tests, surgery or hospitalization (except for those related to HIV or AIDS), which have not been completed, or waiting for a medical diagnosis or results of medical tests or procedures which have not been received?	☐	☐
8. In the past twelve (12) months, have You been diagnosed, treated, tested positive, prescribed medication, or been given medical advice by a member of the medical profession for:		
a. Angioplasty (balloon procedure), stent placement, or heart bypass surgery?	☐	☐
b. Stroke; Heart attack, heart valve disorder, coronary disease, angina (chest pain), or heart disorder (excluding heart murmurs, rhythm disorders, and hypertension)?	☐	☐
9. Have You received advice from a member of the medical profession to have, are You waiting for, or have You ever received, an organ or tissue transplant?	☐	☐
10. Are You now, or within the past six (6) months have you been:		
a. Hospitalized for 48 hours or more, bedridden or confined to or living in a nursing facility or correctional facility?	☐	☐
b. Receiving or been advised by a member of the medical profession to receive hospice care?	☐	☐
c. Receiving home health care for a chronic or debilitating condition?	☐	☐
d. Receiving assistance with activities of daily living, including eating, bathing, toileting, or dressing due to a chronic or debilitating condition?	☐	☐
e. Confined to a wheelchair or using a walker for a chronic illness (except in the case of a temporary condition that is expected to last three (3) months or less)?	☐	☐
f. Using oxygen to assist in breathing?	☐	☐
11. Have You been diagnosed with a terminal illness that is expected to result in death within twenty-four (24) months?	☐	☐