Final Expense or Annuity Application

PROPOSED INSURED/ANNUITANT INFORMATION

Proposed Insured/Annuitant Name

Social Security Number

Street Address

Telephone

City

State

Zip Code

Date of Birth:

Age:

Sex

☐ Male ☐ Female

OWNER INFORMATION

Owner Name, if other than Proposed Insured/Annuitant

Social Security Number

Street Address

Telephone

City

State

Zip Code

Relationship

Date of Birth:

Age:

Sex

☐ Male ☐ Female

REPLACEMENT INFORMATION

Does the Proposed Insured/Annuitant have existing Life Insurance or an Annuity Policy?

☐ Yes ☐ No

Is the policy applied for intended to replace any existing Life Insurance or Annuity Policy?

☐ Yes ☐ No

BENEFICIARY INFORMATION

Primary Beneficiary (#1) Name | **Relationship** | **Percentage**

Street Address | City | State | Zip Code

Telephone | Email

Primary Beneficiary (#2) Name | **Relationship** | **Percentage**

Street Address | City | State | Zip Code

Telephone

Email

Contingent Beneficiary Name

Relationship

Percentage

Street Address

City

State

Zip Code

Telephone

Email

MEDICAL INFORMATION

Please answer each question. All applicants must answer Part 1.

Part 1: In the last two years, has the applicant:

a. Been confined to a hospital or nursing facility (including custodial care) for 5 or more days?

☐ Yes ☐ No

b. Received hospice, home health or adult day care services?

☐ Yes ☐ No

c. Been advised by a medical practitioner to seek such confinement or care, but chose not to follow that advice?

☐ Yes ☐ No

d. Been diagnosed by a medical practitioner as having a terminal illness or condition, or been advised by a medical practitioner that their life expectancy is twelve months or less?

☐ Yes ☐ No

If any question in Part 1 is answered YES, you will be issued the Annuity product – you do not need to answer Part 2 (see following page).

MEDICAL INFORMATION (Continued)

Part 2: In the last two years, has a medical practitioner diagnosed, advised, or treated the applicant for any of the following

☐ Yes ☐ No

AIDS/ARC	HIV Infection	Stroke or Transient Ischemic Attack (TIA)
Liver Disorder	Blood Disorder	Brain Disorder
Alzheimer's / Dementia	Nervous Disorder	Amyotrophic Lateral Sclerosis (ALS)
Kidney Disorder	Insulin Dependent Diabetes	Heart or Circulatory Disorder (including heart attack, coronary heart disease, valve repair or replacement, congestive heart failure)
Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Other Lung Disease	Cancer or Malignant Tumor other than Basal Cell Carcinoma (including lymphoma, leukemia, lesions, polyps)	

If the applicant answers "No" to all of the health questions in Part 1 and Part 2 and signs the application, level death benefit life insurance will be issued. If Part 1 is answered "No" but Part 2 is

answered "Yes", life insurance with limited death benefits during the first two years will be issued. The limited death benefit in the first two years, for causes other than accidental means, is a return of premiums paid with 10% interest compounded annually from the date of each payment to the date of death.

COVERAGE AND PREMIUM PAYMENT INFORMATION

Life Insurance

Total Amount of Insurance

$

Amount of Premium

$

Payment Plan

Continuous Pay

Automatic Premium Loan

☐ Yes ☐ No

Annuity

Total Amount of Annuity

$

Additional Contribution Amount

$

The Maturity Date is the later of attained age 70 or 10 years after the Issue Date unless a later Maturity Date is elected.

Later Maturity Date (if Elected):

Amount Paid with Application

$

Premium Mode

☐ Monthly ☐ Quarterly ☐ Annually

Billing Method

☐ Bank Draft ☐ Visa/Mastercard ☐ Check/Money Order

All premium checks must be payable to American Century Life. Do not make checks payable to the agent or leave the payee's name blank.

REPRESENTATIONS AND SIGNATURES

I represent that all statements and answers contained in this Application are full, complete and true as written and correctly recorded. I understand that a material misrepresentation, untrue declaration, or failure to disclose all material facts may result in loss or cancellation of coverage. I agree: (1) this Application and any contract issued on it shall constitute the entire contract of insurance; (2) no person other than the President or Secretary of the Company can act for it or make, modify or discharge any part of the contract or waive any of the Company's rights and requirements; and (3) No coverage will start unless: (i) a policy is issued; (ii) the policy is accepted; and (iii) the first full premium is paid while all persons to be covered are living and their health remains as stated in this Application. I understand that a copy of this Application will serve as receipt for the amount paid.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Signature of Proposed Insured/Annuitant *	Date *	Name of Insured/Annuitant *	

Search

Quick Links

- Bank Draft Authorization
- Policy Change of Update Form
- Change of Assignment Form
- Death Claim by Funeral Homes

Signature of Parent or Guardian (if Proposed Insured/Annuitant is a Minor)	Date	Signature of Owner (if applicable)	Date

Signature of Agent	Date	Name of Agent	Agent Number

Send