



Single Premium Individual Life Insurance Application With Assignment

PROPOSED INSURED/ANNUITANT INFORMATION

Proposed Insured

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

Social Security Number

Street Address

Telephone

City

State

Zip Code

Relationship

Date of Birth:

Age:

Sex

Male Female

ASSIGNMENT INFORMATION

Assignment: I hereby assign to

all of the benefits being applied for. Such assignment is

Revocable Irrevocable

Street Address

City

State

Zip Code

Telephone

REPLACEMENT INFORMATION

Does the Proposed Insured 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's Name

Relationship

Percentage

Street Address

City

State

Zip Code

Telephone

Email

Contingent's Name

Relationship

Percentage

Street Address

City

State

Zip Code

Telephone

Email

COVERAGE AND PREMIUM PAYMENT INFORMATION

Total Amount of Insurance

Amount of Premium

Amount of Premium

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 *

Date *

Name of Insured *



Signature of Parent or Guardian
(if Proposed Insured is a Minor)

Date

Signature of Owner (if applicable)

Date



Signature of Agent

Date

Name of Agent

Agent Number



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