



Genworth®
Financial

101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

APPLICATION

WHOLE LIFE INSURANCE

Underwritten by
American Continental Insurance Company

Pennsylvania



American Continental Insurance Company
 A Genworth Financial Company
 101 Continental Place
 Brentwood, TN 37027

Application for Whole Life Insurance from American Continental Insurance Company

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- Please print clearly and use blue or black ink.
- Use Section 4 for additional remarks, requests, or explanations.

1. Proposed insured information

If insured's mailing address is different than residential address, use remarks (Section 4).

If billing address is different than residential address, use remarks (Section 4).

Write the date of birth that is on the birth certificate.

Full name of proposed insured *First, M.I., Last*

Residential address (No P.O. Boxes) Phone

City State Zip

E-mail Social Security Number

Birth date *mm/dd/yyyy* Age

Height *Feet and inches* Weight *Pounds* Male Female

Are you a legal resident of the United States? Yes No

Have you used any form of tobacco in the past 12 months? Yes No

2. Benefits, beneficiary and replacement information

To determine which Plan the applicant qualifies for, complete the health questions in Section 3.

Unless otherwise requested, the effective date is the application date as long as the application is received at the Home Office within 15 days.

If a nonforfeiture option is not selected, extended term insurance is the default.

You have a choice of four payment modes for paying your premium. The Company does not charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

Initial amount of insurance applied for:
 \$

Plan requested: Graded benefit plan Level benefit plan

Riders requested (if available):

Requested effective date:

Nonforfeiture options:
 Automatic premium loan
 Paid-up insurance
 Extended term insurance

Amount paid with this application: Initial premium method: EFT Check or money order

\$

Payment mode: Annually Quarterly Semi-Annually Monthly EFT (Electronic Funds Transfer)

Full name of primary beneficiary *First, M.I., Last* Relationship to insured

Contingent beneficiary *First, M.I., Last* Relationship to insured

Does the proposed insured currently have any life insurance or annuity in force? Yes No

Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? Yes No

If the answer to either question is "yes", please provide the information below:

Company name Face amount Policy number

Application for Whole Life Insurance

3. Health questions

A. Graded benefit plan

If you answered "yes" to any questions in Section A, you are not eligible for insurance coverage.

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|
| 1. Do any of the following apply to you? | | |
| A. currently hospitalized, in a nursing facility, confined to a bed, receiving hospice care | <input type="radio"/> Y | <input type="radio"/> N |
| B. require use of oxygen for any lung or respiratory disorder | <input type="radio"/> Y | <input type="radio"/> N |
| C. have been diagnosed by a medical professional as having an aneurysm that has not been surgically repaired | <input type="radio"/> Y | <input type="radio"/> N |
| 2. At any time have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. any condition requiring bone marrow, stem cell, or organ transplant | <input type="radio"/> Y | <input type="radio"/> N |
| B. kidney disease requiring dialysis | <input type="radio"/> Y | <input type="radio"/> N |
| C. Alzheimer's Disease, dementia, mental incapacity | <input type="radio"/> Y | <input type="radio"/> N |
| D. Lou Gehrig's Disease (ALS) | <input type="radio"/> Y | <input type="radio"/> N |
| E. a life expectancy of 12 months or less | <input type="radio"/> Y | <input type="radio"/> N |
| F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) | <input type="radio"/> Y | <input type="radio"/> N |
| 3. Do you have diabetes: | | |
| A. diagnosed by a medical professional before age 40 | <input type="radio"/> Y | <input type="radio"/> N |
| B. in combination with any heart or circulatory disorder diagnosed by a medical professional (excluding high blood pressure) | <input type="radio"/> Y | <input type="radio"/> N |
| C. requiring 40 or more units of insulin daily | <input type="radio"/> Y | <input type="radio"/> N |
| 4. Within the past 12 months has a medical professional diagnosed you as having or have you had surgery for a heart attack, heart valve disorder, heart blockage, stroke or transient ischemic attack (TIA)? | | |
| | <input type="radio"/> Y | <input type="radio"/> N |
| 5. Within the past 12 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. any lung or respiratory disorder requiring the use of a nebulizer | <input type="radio"/> Y | <input type="radio"/> N |
| B. any lung or respiratory disorder and currently use tobacco | <input type="radio"/> Y | <input type="radio"/> N |
| C. internal cancer, melanoma, lymphoma, multiple myeloma, leukemia, systemic lupus (SLE) | <input type="radio"/> Y | <input type="radio"/> N |
| D. chronic pancreatitis, chronic hepatitis, cirrhosis | <input type="radio"/> Y | <input type="radio"/> N |
| 6. Within the past 12 months, have you been recommended by a medical professional to have any of the following? | | |
| A. treatment or counseling for alcohol or drug abuse | <input type="radio"/> Y | <input type="radio"/> N |
| B. test, surgery, treatment or further evaluation that has not been performed or are there any test results pending | <input type="radio"/> Y | <input type="radio"/> N |

B. Level benefit plan

If you answered "yes" to any questions in Section B, you qualify for the Graded benefit plan.

If you answered "no" to ALL questions in Section B, you qualify for the Level benefit plan.

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------|
| 7. Within the past 24 months, has a medical professional diagnosed you as having or have you had surgery for an aneurysm, heart attack, any circulatory disorder, stroke, or transient ischemic attack (TIA)? | | |
| | <input type="radio"/> Y | <input type="radio"/> N |
| 8. Within the past 24 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. emphysema, chronic obstructive pulmonary disease (COPD) | <input type="radio"/> Y | <input type="radio"/> N |
| B. internal cancer, melanoma, leukemia | <input type="radio"/> Y | <input type="radio"/> N |
| C. neuromuscular disorder including, but not limited to, cerebral palsy, multiple sclerosis, muscular dystrophy | <input type="radio"/> Y | <input type="radio"/> N |
| D. any connective tissue disorder, ulcerative colitis, Crohn's disease | <input type="radio"/> Y | <input type="radio"/> N |
| 9. At any time, have you been diagnosed or treated by a medical professional or had surgery for any of the following? | | |
| A. congestive heart failure, cardiomyopathy, Parkinson's disease | <input type="radio"/> Y | <input type="radio"/> N |
| B. any permanent paralysis, amputation caused by disease | <input type="radio"/> Y | <input type="radio"/> N |
| 10. Are you dependent on a wheelchair or motorized mobility device? | | |
| | <input type="radio"/> Y | <input type="radio"/> N |

Application for Whole Life Insurance

4. Remarks

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.....
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5. Privacy notice

Your application and telephone interview are American Continental Insurance Company's primary sources of information in determining whether to provide coverage to you. The Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

6. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

7. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my answers to the questions in this application. The applicant and agent represent that the applicant has read, or had read to applicant, the completed application, and the applicant understands that any false statements or misrepresentations made in the application may result in loss of coverage under the policy to which this application is a part.

I, the applicant, represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that no insurance shall be in effect until the application has been accepted and approved by the Company and the first full modal premium has been paid. I understand that no insurance agent is authorized to waive any part of any answer on the application, to approve insurability, make or modify any contract or waive any of the Company's rights or requirements.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant signature

Date signed

X

.

Owner signature (if not proposed insured)

Owner Social Security Number

X

.

Signed in *City and State*

.

If owner is different than insured, indicate name, address and relationship to insured in remarks (Section 4).

Application for Whole Life Insurance

8. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

•

Account owner name, if different than proposed insured's

•

Account owner relationship to proposed insured:

Business owned

by proposed insured

Living trust

Power of Attorney

Employer

Conservator/guardian

Family member; specify

Financial institution name

•

Checking

Savings

Routing number

•

Account number

•

Initial premium will be drafted when the policy is approved and issued.

Do you prefer to have the initial premium drafted on the Effective Date?

Yes

This is an example of a personal check. A business check may be different.

For all other checks, use the nine-character bank routing number, which appears between the **||** symbols, usually at the bottom left corner of the check.

John Henry Doe
PH. 000-000-0000
1234 Any Street
Mycity, TN 00000

Date _____

Pay to the Order of _____ \$ _____ Dollars

Local Bank
Mycity, TN

ACH RT 012345678

For _____

⑆ 987654321 ⑆ 123456789 001234

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the **||** symbol at the bottom of the check and usually to the right of the bank routing number.

9. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner

Date

X

•

Application for Whole Life Insurance

10. Agent Statement

Number 4 is applicable only if agent has personally recorded the information on the application.

The writing number reflects where commissions will be paid.

I represent the following:

1. That the insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Does the proposed insured have any existing life insurance or annuity contracts? Yes No

Will the policy applied for be a replacement or change existing life insurance or an annuity? Yes No

If the answer to either question is "yes", have you complied with the requirements of the Company and your state regarding this replacement? Yes No

Agent name *Printed*

Writing number (agent or company)

.....

Agent signature

X

Phone

E-mail

.....

11. Policy delivery

The policy will be mailed directly to the policyholder.

12. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Writing agent *Printed*

Percentage

..... %

Secondary agent *Printed*

Writing number

Percentage

..... %

Writing agent signature

X

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.



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American Continental Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, TN 37027

800 264.4000
cont-life.com
office hours 7:30 a.m. - 4:30 p.m. CST

Receipt And Conditional Insurance Agreement

from American Continental Insurance Company
(herein called "Company")

Page 1 of 1

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Receipt for Initial Premium: This acknowledges receipt of the initial premium to be applied in connection with your application to Company for a whole life insurance policy. Company will return your premium payment if Company does not approve your application. This receipt will be void and of no effect if: 1) your check is not payable to American Continental Insurance Company or is not paid upon presentation; or 2) If your EFT bank draft is not honored due to insufficient funds in your bank account.

Proposed insured's name <i>Printed</i>	Date of application
.....
Initial payment collected (if applicable)	
\$	<input type="radio"/> Check <input type="radio"/> Money order
EFT draft amount (EFT authorization must be completed and signed)	
\$	
Agent name <i>Printed</i>	Phone
.....
Agent signature	
X	

If you requested an effective date that is later than your application date, the following agreement will not apply and Company underwriting may consider any changes in your health status which occur after the application date.

Agreement: This Agreement applies only if all of the following requirements have been satisfied:

1. You submit your check payable to American Continental Insurance Company for the initial premium set forth above; or, if payment is made by EFT, you complete the account information and sign the EFT authorization and your financial institution honors the EFT request for payment; and
2. You did not request in writing, an effective date that is later than your application date; and
3. You truthfully answered "NO" to all the health questions in Section 3 of the application; and
4. No material misrepresentation or misstatement was made in the application.

When all of these requirements are satisfied, you and Company agree that:

1. Company will not disapprove your application based on any change in your health status that occurs after the application date.
- 2. If Company approves your application, Company will provide insurance under the policy for which application was made, and the policy will be effective as of the application date.**
3. If Company disapproves your application, you will have no insurance coverage.

No applicant, agent, producer or representative has any power or authority to change any of the provisions of this Agreement.

Thank you for choosing American Continental Insurance Company!