# AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Home Office: P.O. Box 139040, Dallas, TX 75313-9040 • Administrative Office: P.O. Box 13487, Kansas City, MO 64199-3487

## Supplemental Application for Disability Income Rider

Application Number: _____

| 1. Proposed Insured (Print full name) | 2. Amount of Disability Income Desired<br>$_____ Monthly Income |
|---|---|

**Complete this Section for All Applicants**

3. Is the Proposed Insured currently employed full time (30 hours per week) and able to perform all of his or her regular duties?(If "No", give details in **Remarks** section) ❒ Yes ❒ No
4. How long employed with current employer? _____ Yrs. _____ Mos. Annual Salary: $_____
5. Within the past three (3) years, has the Proposed Insured ever been convicted of driving while under the influence? ❒ Yes ❒ No
6. Does the Proposed Insured have any other disability income insurance in force, including state plans or salary continuation? ❒ Yes ❒ No
   (If "Yes", include: Monthly Benefit: $_____ Benefit Period: _____ Type of Coverage: _____
7. Has there been any disability claims in the past five (5) years? ❒ Yes ❒ No
8. Is the Proposed Insured now pregnant? ❒ N/A (If "Yes", how many months: _____) ❒ Yes ❒ No
9. Within the past ten (10) years, has the Proposed Insured ever been treated for:
   (a) Paralysis, deformity, loss of limb or any disorder of the eyes, ears, nose or throat? ❒ Yes ❒ No
   (b) Epilepsy, convulsions, depression or any disorder of the thyroid, pancreas or other glands? ❒ Yes ❒ No
   (c) Varicose veins, phlebitis, anemia, leukemia, bleeding tendency or any other disorder of the blood or blood vessels? ❒ Yes ❒ No
   (d) Ulcer, hernia, hemorrhoid, colitis or any disorder of the stomach, intestines, rectum or gallbladder? ❒ Yes ❒ No
   (e) Venereal disease or any disorder of the bladder, prostate, uterus, breast or reproductive organs? ❒ Yes ❒ No
   (f) Arthritis, gout or any disorder of the muscles or bones including the spine, back and joints? ❒ Yes ❒ No

**Complete this Section if Rider is Being Added to an Existing Policy** — Policy Number:

| 10. Face Amount of Policy | 11. Current Premium | 12. DIR Premium | 13. New Total Premium | 14. Effective Date |
|---|---|---|---|---|
| $ | $ | $ | $ | |

| 15. Occupation (Give title and duties) | 16. Employer/Business Address | 17. Phone Number<br>Home: ( )<br>Work: ( ) |
|---|---|---|
| | | |

18. Within the past three (3) years, has the Proposed Insured ever had his or her driver's license suspended or revoked or received 3 or more moving violations? (If "Yes", give details and driver's license number and state in **Remarks** section.) ❒ Yes ❒ No
19. Has the Proposed Insured consulted a physician or been hospitalized for any reason in the past five (5) years? ❒ Yes ❒ No
20. Has the Proposed Insured ever been diagnosed as having or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any immune deficiency related disorder or tested positive for antibodies to the HIV virus? ❒ Yes ❒ No

**Remarks**

Please provide details for all "YES" answers given above. Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities, as applicable.

I/we represent to the Company that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief and that the Company can rely on these statements. I/we further agree that this supplemental application shall be made a part of the policy to which it applies.

Signed at _____ (City and State) on _____ (Month, Day, Year)

| Proposed Insured | Owner (if other than Proposed Insured) | Witness (Agent) |
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