800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Application

Whole Life Insurance

Underwritten by

An Aetna Company **American Continental Insurance Company**

Michigan

American Continental Insurance Company
An Aetna Company

800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067

Application for Whole Life Insurance
from American Continental Insurance Company

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

1. Proposed insured information

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

Address | Phone

City | State | Zip

E-mail | Social Security Number

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

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 owner information

Initial amount of insurance applied for:
$

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

Plan requested:
○ Modified benefit plan
○ Graded benefit plan
○ Level benefit plan

Riders requested (if available):

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

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

Amount paid with this application:
$

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.

Payment mode:
○ Annually ○ Semi-Annually
○ Quarterly ○ 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

3. Health questions

A. Modified 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 ○ Y ○ N
   - B. require use of oxygen for any lung or respiratory disorder ○ Y ○ N
   - C. have been diagnosed by a medical professional to have an aneurysm that has not been surgically repaired ○ Y ○ 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 ○ Y ○ N
   - B. kidney disease requiring dialysis ○ Y ○ N
   - C. Alzheimer's Disease, dementia, mental incapacity ○ Y ○ N
   - D. Lou Gehrig's Disease (ALS) ○ Y ○ N
   - E. a life expectancy of 12 months or less ○ Y ○ N
   - F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) ○ Y ○ N

B. Graded benefit plan

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

3. Do you have diabetes?
   - A. diagnosed by a medical professional before age 40 ○ Y ○ N
   - B. in combination with any heart or circulatory disorder diagnosed by a medical professional (excluding high blood pressure) ○ Y ○ N
   - C. requiring 40 or more units of insulin daily ○ Y ○ N

4. Within the past 12 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. heart attack, heart valve disorder, heart blockage, stroke or transient ischemic attack (TIA) ○ Y ○ N
   - B. any lung or respiratory disorder requiring the use of a nebulizer ○ Y ○ N
   - C. any lung or respiratory disorder and currently use tobacco ○ Y ○ N
   - D. internal cancer, melanoma, lymphoma, multiple myeloma, leukemia, systemic lupus (SLE) ○ Y ○ N
   - E. chronic pancreatitis, chronic hepatitis, cirrhosis ○ Y ○ N

5. 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 ○ Y ○ N
   - B. test, surgery, treatment or further evaluation that has not been performed or are there any test results pending ○ Y ○ N

C. Level benefit plan

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

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

6. Within the past 24 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?
   - A. aneurysm, heart attack, any circulatory disorder, stroke or transient ischemic attack (TIA) ○ Y ○ N
   - B. emphysema, chronic obstructive pulmonary disease (COPD) ○ Y ○ N
   - C. internal cancer, melanoma, leukemia ○ Y ○ N
   - D. neuromuscular disorder including, but not limited to, cerebral palsy, multiple sclerosis, muscular dystrophy ○ Y ○ N
   - E. any connective tissue disorder, ulcerative colitis, Crohn's disease ○ Y ○ N

7. 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 ○ Y ○ N
   - B. any permanent paralysis, amputation caused by disease ○ Y ○ N

8. Are you dependent on a wheelchair or motorized mobility device? ○ Y ○ N

4. Remarks

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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)

X .....

Signed in *City and State*

.....

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 ◯ Employer

◯ Power of Attorney ◯ Conservator/guardian

◯ Family member; specify ▪

Financial institution name

▪

◯ Checking ◯ Savings

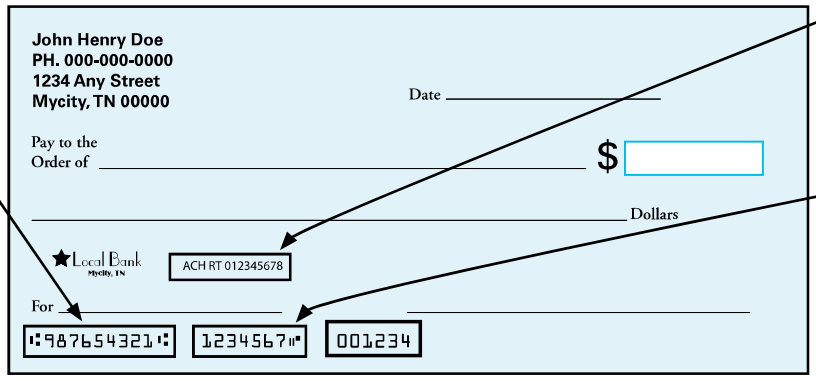
Routing number

▪

Account number

▪

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.

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 ▪

10. Agent Statement

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.

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

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

The writing number reflects where commissions will be paid.

Agent name *Printed* .

Writing number (agent or company) .

Agent signature

X

Phone .

E-mail .

11. 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 . %

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

Writing agent signature

X

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office hours 7:30 a.m. - 4:30 p.m. CST

Receipt
from American Continental Insurance Company

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

Proposed insured's name *Printed*

Date of application

Initial payment collected (if applicable)

$ ◯ Check ◯ Money order

EFT draft amount

$

This acknowledges receipt of your application for an American Continental Insurance Company Whole Life insurance policy.

Agent name *Printed*

Phone

Agent signature

X

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Thank you for choosing American Continental Insurance Company!

aetna SM

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An Aetna Company

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Suite 200
Franklin, TN 37067

Health Information Authorization

from American Continental Insurance Company

- Print clearly and use blue or black ink.
- This is a HIPAA Compliant Authorization.

To Agent: Have applicant complete and sign home office copy to submit with application. Applicant keeps one copy.

Applicant declarations

Please read these statements carefully

I authorize the use and disclosure of health information about me as described herein.

Health Information to be Used or Disclosed: This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present, or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; alcoholism and mental illness; and may be in electronic or paper form. It does not include information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Continental Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to American Continental Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant — Date

X .

Printed name of applicant

X

City — State — Zip

. . .

Other important information

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.

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Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Continental Insurance Company; its insurance support organizations; its affiliates and reinsurers.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: physicians; health professionals; hospitals; clinics; the Veterans Administration; or other medical or medically related facilities; care providers or evaluators; insurance companies; reinsurers; consumer reporting agencies; insurance support organizations.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my application; determine premium amounts, adjudicate claims and to support the operations of our health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization; and that a copy of it is as valid as the original; (2) this Authorization will be valid for 24 months from the date signed; (3) if I do not sign this Authorization, or revoke it by writing to American Continental Insurance Company at its Administrative Office, the Company may decline my application; and (4) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization (5) Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Primary applicant please fill in this information

Signature of applicant — Date

X .

Printed name of applicant

X

City — State — Zip

. . .

Other important information

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.

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PRODUCER STATEMENT

In connection with a Replacement of Insurance Transaction:
I certify that:

- I have used only American Continental Insurance Company approved sales material
- I have left all sales materials and the Replacement Notice with the applicant, and
- This sale conforms with the company's replacement policy.

The form number(s) of the sales materials left with the applicant are noted below. If no sales materials were used, state "none".

_____ _____

_____ _____

_____ _____

Date: _____

_____
Producer's Signature

_____
Producer's Name

Replacement Policy

We believe that the replacement of an existing life insurance policy must be appropriate for the customer and must meet his or her needs or financial objectives. From a customer's perspective, an appropriate replacement is one that is justified from either an economic or personal standpoint. The costs, provisions, features and benefits of both the current and proposed policy should be considered in relation to the customers needs, circumstances and goals.

Some examples of the types of provisions that should be considered are premium rate differences and differences in suicide and incontestability provisions. In addition, factors such as the age and health of the customer must be considered. Producers are expected to provide all material information that the customer needs in order to ascertain whether replacement of an existing policy or contract is appropriate.

All replacements must be in compliance with applicable regulations and company rules. Many states require accurate written comparisons of existing and proposed contracts be provided to the customer when proposing a replacement. Producers are expected to know and comply with these requirements.

American Continental Insurance Company

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NOTICE TO APPLICANTS
REGARDING REPLACEMENT OF LIFE INSURANCE

THIS NOTICE IS FOR YOUR PROTECTION AND IS REQUIRED BY REGULATIONS OF THE MICHIGAN COMMISSIONER OF INSURANCE. PLEASE READ IT CAREFULLY.

Dropping or changing your existing life insurance to replace it with a new life insurance policy may be disadvantageous because:

A company can deny a claim during the first two years if it can be shown that you withheld information from your application which was important to the decision of whether to insure you. This is called the "CONTESTABLE PERIOD." If you drop or change policies, you may have to go through the two year period again.

You may pay HIGHER RATES for identical coverage because of your age. Life insurance rates go up as you get older.

BEFORE YOU DROP, CHANGE OR CASH IN YOUR PRESENT INSURANCE and apply for new insurance, you should:

1. Compare the policy BENEFITS and OPTIONS. The agent is required by law to provide you with all pertinent facts of the change and the insurance company you are considering must notify the company that issued your existing policy.

2. Be aware that you may be required to provide EVIDENCE OF INSURABILITY. If your health condition has changed since the application was taken on your present policy, you may be required to pay additional premiums under the new policy, or be denied coverage.

3. Compare the LOAN INTEREST RATE. The interest rate for new policies is probably higher than for the existing policy. Therefore, you will pay more when you want to borrow the cash value. If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy.

4. Find out if the existing policy and/or the proposed policy offers DIVIDENDS OR EXCESS INTEREST. Dividends or excess interest can have a significant impact or net policy cost. Remember that no company can guarantee the amount of dividends it will pay in the future, nor can excess interest projections be presented as to imply a guarantee.

5. CONTACT THE AGENT OF YOUR PRESENT COMPANY. Your present company can often make changes in your existing insurance on terms which are more favorable to you than can another company.

6. Find out if there are income or estate tax consequences if you drop or change your present policy.

You should not drop or change your existing life insurance coverage until after you have been issued the new policy, examined it and found it to be acceptable to you. REMEMBER YOU HAVE TEN DAYS AFTER RECEIPT OF THE POLICY TO CANCEL AND OBTAIN A FULL REFUND.

Date:_____ Applicant's Signature_____

American Continental Insurance Company

An Aetna Company

800 Crescent Centre Dr., Suite 200 • Franklin, Tennessee 37067 • 800 264.4000

INFORMATION STATEMENT

THE LIFE INSURANCE I INTEND TO PURCHASE FROM
AMERICAN CONTINENTAL INSURANCE COMPANY
MAY REPLACE OR ALTER EXISTING LIFE INSURANCE

The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number

The proposed policy is:

_____ $_____
Type of policy - generic name — Face amount

_____ _____
Signature of Applicant — Date

_____
Address of Applicant — City — State

I certify that this form and the Notice to Applicants Regarding Replacement of Life Insurance were given to and signed by

_____
(Applicant - Please print of type)

prior to taking an application and that I am leaving a signed copy for the applicant.

_____ _____
Date — Agent's Signature

_____
Address

_____
City — State

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Date:_____ Applicant's Signature_____

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Address of Applicant — City — State

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_____
(Applicant - Please print of type)

prior to taking an application and that I am leaving a signed copy for the applicant.

_____ _____
Date — Agent's Signature

_____
Address

_____
City — State