# Application for

Over 50 Years
Serving The South
Since 1952

# Accident & Health Insurance


LIFE INSURANCE COMPANY OF ALABAMA
302 BROAD STREET • P.O. BOX 349 • GADSDEN, AL 35902
1-800-226-2371 • FAX 256-549-0070


Form MP A&H 09-05

# LIFE INSURANCE COMPANY OF ALABAMA

HOME OFFICE – GADSDEN, ALABAMA

| HEIGHT AND MAXIMUM WEIGHT CHART | | | | |
|---|---|---|---|---|
| Height | Major Expense Plan-Lump Sum Heart / Heart Stroke Plan | The Income Protector - Sickness and Accident Disability Income | Sickness Disability Rider | Inpatient + Outpatient Medical Indemnity Plan |
| 4’10” | 160 | 178 | 198 | 198 |
| 11” | 164 | 181 | 201 | 205 |
| | | | | |
| 5’ 0” | 168 | 185 | 205 | 212 |
| 1” | 176 | 190 | 210 | 218 |
| 2” | 180 | 195 | 215 | 227 |
| 3” | 188 | 200 | 220 | 235 |
| | | | | |
| 4” | 196 | 206 | 225 | 241 |
| 5” | 202 | 212 | 230 | 248 |
| 6” | 208 | 217 | 236 | 256 |
| 7” | 215 | 222 | 242 | 263 |
| | | | | |
| 8” | 222 | 228 | 249 | 271 |
| 9” | 230 | 234 | 256 | 279 |
| 10” | 238 | 240 | 263 | 286 |
| 11” | 246 | 246 | 271 | 293 |
| | | | | |
| 6’ 0” | 254 | 252 | 279 | 297 |
| 1” | 260 | 258 | 287 | 305 |
| 2” | 267 | 265 | 295 | 313 |
| 3” | 273 | 272 | 303 | 321 |
| | | | | |
| 4” | 280 | 279 | 311 | 330 |
| 5” | 286 | 287 | 319 | 341 |
| 6” | 293 | 293 | 327 | 351 |
| 7” | | 300 | 335 | 360 |
| | | | | |
| 8” | | 307 | 343 | 368 |

## APPLICATION FOR ACCIDENT & HEALTH - PART 1

**Please Use Dark Ink Suitable for Photocopying.**

# Life Insurance Company of Alabama

P. O. Box 349 • Gadsden, Alabama 35902

All Shaded areas must be completed.

| 1. PROPOSED INSURED ☐Married ☐Divorced ☐Widowed ☐Single ☐Separated LAST NAME FIRST M.I. | BIRTHDATE MO | DAY | YR | AGE | STATE OF BIRTH | SEX | SOCIAL SECURITY # | HEIGHT (FT. IN.) | WEIGHT (LBS.) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| SPOUSE or OTHER INSURED | | | | | | | | | |
| DEPENDENT CHILDREN PROPOSED for INSURANCE | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| 2. RESIDENCE ADDRESS STREET | CITY | COUNTY | STATE | ZIP | How long at this address? ____ Years Months. If less than 2 years, give previous address under "Special Requests" |
|---|---|---|---|---|---|

| 3. INSURED'S EMPLOYER | EMPLOYMENT DATE | OCCUPATION (Describe and give exact duties) |
|---|---|---|

| 4. OTHER INSURED'S EMPLOYER | OCCUPATION (Describe and give exact duties) | PHONE: RES: ( ) BUS: ( ) | SEND MAIL TO ☐ Residence ☐ Business |
|---|---|---|---|

**IMPORTANT NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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 may be subject to fines and confinement in prison.

## ACCIDENT & HEALTH INSURANCE

**CANCER** *☐ Ultimate III w/ $100 Wellness *☐ Ultimate III *☐ Economizer III
Daily Room ☐ $300 ☐ $250 ☐ $200 ☐ $100
Rad. & Chemo. ☐ $25,000 ☐ $20,000 ☐ $15,000 ☐ $10,000 per yr.
☐ Return of Premium
☐ Individual ☐ One Parent ☐ Two Parent
*Answer Question 11* $________ **Mode Prem.**

**FIRST OCCURRENCE RIDER:**
HC74-06 ☐ $5,000 ☐ $2,500
HC40-91 ☐ 1 Unit ☐ ½ Unit (Building Benefit) $________ **Mode Prem.**

**INTENSIVE CARE BENEFIT:** ☐ *Rider ☐ ✤Stand Alone
☐ I-63 (highest level only) ☐ I-66 (half unit step down)
☐ $300 ☐ $450 ☐ $600 ☐ Other __________ $________ **Mode Prem.**
☐ Individual ☐ One Parent ☐ Two Parent
**Answer Question 12 ✤Answer Question 20*

**DREAD DISEASE BENEFIT RIDER** **Answer Question 13*
☐ Individual ☐ One Parent ☐ Two Parent $________ **Mode Prem.**

**THE MAJOR EXPENSE PLAN** *
☐ Can. & Heart Combo $__________ (FACE AMOUNT) ☐ Can. Only $__________ (FACE AMOUNT)
☐ Non-Tobacco User ☐ Tobacco User ☐ Hrt. Only $__________ (FACE AMOUNT)
☐ Individual ☐ One Parent ☐ Two Parent
*Record Height & Weight above for Lump Sum Heart Benefit* $________ **Mode Prem.**
**Answer Questions 14 & 16 for Cancer / Questions 15 & 16 for Heart*

**ACCIDENT DISABILITY PLAN** * ☐ A-34
(90 Day Employment Required - Record Employment Date Above)
☐ Individual ☐ One Parent ☐ Two Parent
Monthly Income $__________
Applicant's Gross Monthly Income $__________ $________ **Mode Prem.**
Broken Bone Benefit Units ☐ 1 ☐ 2 ☐ 3
✠Sickness Disability Rider Mo. Inc. $__________
Elimination ☐7 or ☐14 days
**Answer Question 10(a) ✠Record Height & Weight Above & Answer 17, 19, & 20*

**ACCIDENT INCOME PROVIDER** * ☐ $3000 ☐ $1500
☐ Individual ☐ One Parent ☐ Two Parent ☐ Two Adult
**SENIOR ACC. INCOME PROVIDER** * ☐ $3000 ☐ $1500
☐ Individual ☐ One Parent ☐ Two Parent ☐ Two Adult
**Answer Question 10(a)* $________ **Mode Prem.**

**HEART STROKE EXPENSE PLAN** *
☐ Hospital Confinement Units ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Individual ☐ One Parent ☐ Two Parent
**Record Height & Weight above & answer Question 18* $________ **Mode Prem.**

**INPATIENT + OUTPATIENT HOSPITAL INDEMNITY PLAN**✠ $__________ DAILY BENEFIT
☐ Payroll Only Plan (HI67) ☐ Individual Non-Payroll Plan (HI68)
☐ Individual ☐ One Parent ☐ Emp. & Spouse ☐ Two Parent
OPTIONAL BENEFITS: Initial Conf. $__________
Surg. Benefit $__________ Emer. Acc. $__________
Outpat. Sickness $__________ Other $__________
Major Injury Units ☐ 1 ☐ 2 ☐ 3 $__________ $________ **Mode Prem.**
*✠Record Height & Weight Above & Answer Questions 10(a), 17, 19, and 20*

**THE INCOME PROTECTOR** * ☐ Standard ☐ Preferred
(90 Day Employment Required - Record Employment Date Above)
Generic ☐ or Packaged Plans: ☐ 300 ☐ 600 ☐ 900 ☐ 1200
Applicant's Monthly Income $ __________ $________ **Mode Prem.**
✪Monthly Disability Benefit $ __________
Benefit Period ☐ 6 months ☐ 1 Year ☐ 2 Years
**Sickness Elimination Period** _______ days
Optional Benefits:
✪Monthly Hospital Benefit $__________
✪Accidental Death & Dismemberment Benefit $__________
Broken Bone Benefit Units ☐ 1 ☐ 2 ☐ 3 $__________
Income Protector Total $__________ **Mode Prem.**
*✪Not Applicable to Pre-packaged Plans*
**Record Height & Weight Above & Answer Questions 10(a), 17, 19, & 20*

**Total of all Health Plans** **$**__________

HOME OFFICE USE

FORM MP A&H 09-05

## APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 2

**5.** Will the policy applied for replace any insurance in force on any proposed covered person? ☐ Yes ☐ No

**7.** Health and Disability Insurance in force (if none, so state)

| *Company* | *Amount* | *Year Issued* |
|---|---|---|
| | | |

**8.** Primary Beneficiary & Relationship

**9.** Contingent Beneficiary & Relationship

***Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 4 of this application. Persons named may be excluded from coverage.***

**10a.** Is any proposed insured currently in the hospital or receiving disability payments? Yes ☐ No ☐

Answer 10(b) when offering a plan approved for E-Z Underwriting

***10b.*** *In the past 5 years has any proposed insured had any known indication of or been treated for a heart attack, internal cancer, melanoma, disease or disorder of the lungs, hepatitis, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV)?* Yes ☐ No ☐

**11. CANCER ULTIMATE III & ECONOMIZER III:**

***Answer Question 14 for The Major Expense Plan ( Lump Sum Cancer)***

**(a)** Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.)? Yes ☐ No ☐

**(b)** Has any person proposed for coverage under this Policy within the last 7 years, been diagnosed as having or been treated for any cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form? Yes ☐ No ☐

**(c)** Has any person proposed for coverage under this Policy now or has ever been diagnosed as having or been treated for acquired immune deficiency syndrome (AIDS), in any form, and no person to be insured under this Policy has tested positive for the human immunodeficiency virus (HIV)? Yes ☐ No ☐

**12. INTENSIVE CARE RIDER:** Has any proposed insured ever been diagnosed or treated for heart disease, heart attack, any heart condition, heart trouble or any abnormality of the heart, acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV)? Yes ☐ No ☐

**(b)** If this is a Two Parent Family Policy/Rider, is any person to be insured currently pregnant or taking fertility drugs? Yes ☐ No ☐

**(c)** If this is a One Parent Family Policy/Rider, are you, your fiancee or companion currently pregnant or taking fertility drugs? Yes ☐ No ☐

**If yes to question (b) or (c), we will issue an individual policy/rider on the adult male family member only.**

***Answer Question 20 for Intensive Care Stand Alone Policy***

**6. PREMIUM MODE & METHOD:** Monthly Direct Bill **Not** Available

☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

☐ Bank Draft ☐ Payroll Deduction ☐ Direct Bill ☐ Family Bill

***Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 4 of this application. Persons named may be excluded from coverage.***

**13. DREAD DISEASE RIDER:**

Has any person proposed for coverage under this Policy ever had treatment or diagnosis of: Adrenal Hypofunction (Addisons's Disease) • Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) • Cystic Fibrosis • Diphtheria • Encephalitis • Legionnaire's Disease (excluding Pontiac Syndrome) • Menningitis (Epidemic Cerebrospinal) • Multiple Sclerosis • Muscular Dystrophy • Myasthenia Gravis • Lyme Disease • Niemann-Pick Disease • Osteomyelitis • Neurolysis • Poliomyelitis • Rabies • Reye's Syndrome • Rheumatic Fever • Rocky Mountain Spotted Fever • Scarlet Fever • Sickle Cell Anemia • Smallpox • Tay-Sachs Disease • Tetanus • Toxic Epiderimal • Toxic Shock Syndrome • Tuberculosis • Tularemia • Typhoid Fever • Whipple's Disease (Intestinal Lipodystrophy)? Yes ☐ No ☐

**14. MAJOR EXPENSE PLAN** (Lump Sum Cancer)**:**

**(a)** Has any person proposed for coverage under this Policy within the last 24 months, had any elevated or rising PSA or CEA test or abnormal mammogram, pap smear, radiological exam (e.g. X-Ray, MRI, CAT Scan), biopsy or scope procedure (e.g. colonoscopy, endoscopy, etc.)? Yes ☐ No ☐

**(b)** Has any person proposed for coverage under this Policy ever been diagnosed as having or been treated for cancer, including skin cancer, Hodgkin's Disease and Leukemia, in any form? Yes ☐ No ☐

**(c)** Has any person proposed for coverage under this Policy ever been diagnosed as having or been treated for acquired immune deficiency syndrome (AIDS), in any form, and no person to be insured under this Policy has tested positive for the human immunodeficiency virus (HIV)? Yes ☐ No ☐

***Answer Question 16***

**15. MAJOR EXPENSE PLAN** (Lump Sum Heart)**:**

**(a)** Has any person proposed for coverage under this Policy ever been diagnosed as having or ever been treated for any of the following conditions in any form: (a) myocardial infarction or heart attack; (b) any disease, disorder or abnormality of the heart or coronary arteries, or any heart related condition; or (c) stroke or transient ischemic attack (TIA); or (d) diabetes; or (e) lung disease? Yes ☐ No ☐

**(b)** Has any person proposed for coverage under this Policy ever had or ever been advised to have: (a) any form of heart surgery, coronary artery surgery, or heart related surgery; or (b) an arteriogram, angioplasty, or pacemaker installed? Yes ☐ No ☐

***Record Height & Weight of all proposed for coverage in Part 1 of Application and answer Question 16***

**16. HAS ANY PERSON** proposed for insurance in Part 1 on reverse side used tobacco in any form within the past 24 months? (If yes, give name and details in Part 4 of this application) Yes ☐ No ☐

**17. INPATIENT + OUTPATIENT MEDICAL EXPENSE PLAN (HI 67), SICKNESS DISABILITY RIDER, THE INCOME PROTECTOR** *(Sickness & Accident Disability)* Is proposed primary insured working at least 30 hours per week? Yes ☐ No ☐

***Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 4 of this application. Persons named may be excluded from coverage.***

**18. HEART STROKE EXPENSE PLAN:**

**(a)** Has any person proposed for coverage under this Policy ever been diagnosed as having, been treated for, received medical advice, or taken prescription medication for High Blood Pressure? Yes ☐ No ☐

**(b)** Has any person proposed for coverage under this Policy ever been diagnosed as having or been treated for acquired immune deficiency syndrome (AIDS), in any form, or tested positive for the human immunodeficiency virus (HIV)? Yes ☐ No ☐

**(c)** Has any person proposed for coverage under this Policy ever been diagnosed as having, or been treated for, received medical advice or taken prescription medication for Stroke, transient ischemic attack (TIA), or any disease, disorder or abnormality of the brain or circulatory system (arteries, veins, lymph nodes, and vessels) (a) myocardial infarction or heart attack; (b) any disease, disorder or abnormality of the heart or coronary arteries, or any heart related condition? Yes ☐ No ☐

**(d)** Has any person proposed for coverage under this Policy ever been diagnosed as having, been treated for, received medical advice or taken prescription medication for: (a) diabetes; or b) lung or respiratory system disease or disorder? Yes ☐ No ☐

**(e)** Has any person proposed for coverage under this Policy ever had or been advised to have: (a) any form of heart surgery, coronary artery surgery, or heart related surgery; (b) an arteriogram, angioplasty, or pace maker installed? Yes ☐ No ☐

***Record Height & Weight of all proposed for coverage in Part 1 of Application***

***Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 4 of this application. Persons named may be excluded from coverage.***

**NOTE:** Questions 19 & 20 must be answered when applying for Inpatient + Outpatient Medical Expense Plan, Sickness Disability Rider and The Income Protector unless approved for E-Z Underwriting. Question 20 must be answered for Intensive Care Stand Alone Policy.

***Details of questions answered "Yes," provide question # and name of proposed insured to which history pertains in Part 4 of this application. Persons named may be excluded from coverage.***

**19. HAS ANY PERSON** proposed for coverage, including children:

**(a)** Contemplated flying or flown as pilot, student pilot or crew member during the last two years? *(If yes, complete Aviation Questionnaire)* Yes ☐ No ☐

**(b)** Any past, present or expected activity in racing, skin or sky diving or any other hazardous sport or hobby? *(If yes, complete Hazardous Sports Questionnaire.)* Yes ☐ No ☐

**(c)** Had any application or policy for life or health insurance been declined, special rated, restricted, postponed, cancelled or reinstatement denied? Yes ☐ No ☐

**(d)** Had driver's license suspended or revoked in past 24 months? Yes ☐ No ☐

**20. HAS ANY PERSON** to be covered ever had or been told or been treated for:

**(a)** Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) by a medical professional? Yes ☐ No ☐

**(b)** Disease or disorder of the heart or blood vessels, chest pain, high or low blood pressure? Yes ☐ No ☐

**(c)** Disease or disorder of the nervous system to include mental disorder, epilepsy or paralysis? Yes ☐ No ☐

**(d)** Disease or disorder of the respiratory system to include emphysema or asthma? Yes ☐ No ☐

**(e)** Disease or disorder of stomach, liver, intestines, bladder, kidney, or reproductive organs, hemorrhoids or hernia? Yes ☐ No ☐

**(f)** Cancer, tumor, diabetes, Leukemia, gland or blood disorders? Yes ☐ No ☐

**(g)** Alcohol or drug usage or abuse? Yes ☐ No ☐

**(h)** Is any person to be covered, currently pregnant or taking fertility drugs? *(If yes, answer question 12 b & c)* Yes ☐ No ☐

**(i)** Within the last five years, has any person to be covered had any ailment of the back or had any other medical advice, treatment or surgery not already listed? Yes ☐ No ☐

**DETAILS** of questions 10-20 answered "yes" including question number, names and addresses of physicians and individuals to whom history pertains, should be listed in Part 4 of this Application.

## APPLICATION FOR ACCIDENT & HEALTH INSURANCE - PART 4

**DETAILS** of questions 10-20 answered "yes" including question number, names and addresses of physicians and individuals to whom history pertains.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

If the proposed insured and any children proposed for insurance are deemed to be insurable at standard rates, the insurance shall become effective on the date hereof, otherwise the insurance shall not take effect until a policy is issued and the first premium paid.

**CERTIFICATION-** The Applicant hereby makes application to Life Insurance Company of Alabama for a policy or policies of insurance and represents that the statements and answers set forth under Parts 1, 2, 3 and 4 of this application by whomsoever written, are full, complete and true to the best of Applicant's knowledge and belief and agrees that they shall be considered as the basis of any insurance which may be issued hereon. The undersigned applicant and agent acknowledge that the applicant has read, or had read to him/her, the completed application and that he/she realizes that policy issuance is based upon statements and answers provided herein.

**AUTHORIZATION-** By this form (or a photographic copy of it), I authorize any licensed physician, medical practitioner, clinic hospital, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of anyone proposed for coverage for whom insurance application is made, to give to The Life Insurance Company of Alabama, or it's reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I also acknowledge that I have received the Investigative Consumer Reports notification and Important Notice attached to this application. This authorization shall be valid for 30 months from the date it is signed.

**As normal procedure, the Home Office Underwriting Department may contact you by telephone to verify pertinent information contained in your application. What is the best way to reach you?**

**Home/Office Phone:**
**Cell Phone:**
**Email address:**

I, the agent, hereby certify by my signature below that, I have truly and accurately recorded on this application the information supplied by the applicant.

X ______________________________________________
Witness (Licensed Resident Agent, if required)

X ______________________________________________
Agent Agent's No.

X ______________________________________________
Agent Agent's No.

**AGENT'S STATEMENT:** To the best of your knowledge does this insurance replace any existing insurance? ☐ Yes ☐ No
If Yes, give name of company and policy number.

Arkansas Only:
No person to be covered for specified disease is also covered by any Title XIX program Medicaid or similar coverage.
☐ Yes ☐ No

Signed at ______________________________________
City State

Date ______________________________________
Month Day Year

X ______________________________________
Signature of Proposed Primary Insured

X ______________________________________ - -
Signature of Owner or Other Insured Social Security or Tax ID #

# IMPORTANT NOTICE

The underwriting process (evaluation and classification of risks) is necessary to assure reasonable cost of insurance and provide a mechanism by which policyholders pay their fair share of the cost. In considering your application, information from various sources is considered, including your own statements, the results of your physical examination (if required), and any reports we obtain from doctors or medical facilities where you have been attended.

Information regarding your insurability will be treated as confidential. We or our Reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 866-692-6901 (TTY 866-346-3642).

We or our reinsurers may release information in our file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

The purpose of the bureau is to protect its members and their policyholders from the extra expense created by those who omit or conceal information relevant to their insurability. Information furnished by the Bureau may serve to alert the company to a need for further investigation but under Bureau rules cannot be used either wholly or partly as the basis for increasing the charge for or denying the issuance of insurance. Information in the Bureau gives no indication regarding the action taken on an application (i.e., whether accepted standard, accepted with increased premium, or declined).

## BILLING DATA AND PAYROLL DEDUCTION AUTHORIZATION

PART I - REQUIRED ON EACH SALARY SAVINGS POLICY (***PLEASE PRINT OR TYPE***)

| EFFECTIVE DATE | NAME OF EMPLOYEE | SOCIAL SECURITY NO. |
|---|---|---|
| DEPT. NO. | NAME OF EMPLOYER | MONTHLY PREMIUM |
| EMP. NO. | INDICATE TYPE OF COVERAGE | WEEKLY PREMIUM |

### PART II - REQUIRED IF A PREMIUM IS TO BE PAID BY EMPLOYEE

I hereby request and authorize you to deduct the premium from my wage and to transmit it to Life Insurance Company of Alabama. These deductions are to cover the premiums on the insurance policy or policies I have applied for. This authorization also allows you to increase my deduction for any rate increases which may be required on these policies.

Deductions shall commence as of the effective date of the policies and continue thereafter until (1) Completion of the premium paying period as provided in the policies, or (2) Upon termination of employment or, (3) Upon written notice by me of the cancellation of this payroll deduction authorization to you and to Life Insurance Company of Alabama or, (4) Termination of this salary deduction plan.

I understand that if, for any reason, this payroll deduction authorization is cancelled I may personally submit premiums for these policies to Life Insurance Company of Alabama.

_______________ DATE    X _______________ SIGNATURE OF EMPLOYEE

## AUTHORIZATION TO HONOR CHECKS DRAWN BY AND PAYABLE TO THE LIFE INSURANCE COMPANY OF ALABAMA, GADSDEN, ALABAMA

To _______________________________ Bank

Branch Name , if any _______________________________

Bank Address _______________________________

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of the Life Insurance Company of Alabama, Gadsden, Alabama provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of The Life Insurance Company of Alabama to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_______________ Date    _______________ Bank Account    X _______________ Bank Signature of Depositor

## INVESTIGATIVE CONSUMER REPORTS

Under Public Law 91-508, we are required to inform persons proposed for insurance that, as part of our regular underwriting procedure, an investigative consumer report may be obtained, which will provide applicable information concerning character, general reputation, personal characteristics, and mode of living. This information will be obtained through personal interviews with your friends, neighbors, and associates. Upon written request to the Manager-Individual Policy Department at Life Insurance Company of Alabama, P.O. Box 349, Gadsden, Alabama 35902, further information on the nature and scope of the report will be provided.

Date __________ ______________________________
Signature of Proposed Primary Insured

Date __________ ______________________________
Signature of Applicant or Owner, if other than Proposed Insured

Date __________ ______________________________
Signature of Other Insured, if applied for

THIS NOTIFICATION MUST BE DELIVERED TO THE PERSON NAMED ABOVE.

**Life Insurance Company of Alabama**

Home Office, Gadsden, Alabama

## THIS PLAN IS MADE AVAILABLE WITH THE APPROVAL AND COOPERATION OF YOUR EMPLOYER

To: The Bank named on the reverse side.

Life Insurance Company of Alabama agrees:

(1) To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.

(2) In the event that any such check, draft or order shall be dishonored whether with or without cause and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.

(3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

LIFE INSURANCE COMPANY OF ALABAMA, Gadsden, Alabama

President

Authorized in resolution adopted by the Executive Board of The Life Insurance Company of Alabama on April 29, 1974