AMERICAN SAVINGS LIFE INSURANCE COMPANY

Remembrance

Single Premium Whole Life Insurance

Application for Single Premium Whole Life Insurance

AMERICAN SAVINGS LIFE INSURANCE COMPANY
935 E. Main Street, Mesa, Arizona 85203-8849
www.AmericanSavingsLife.com

1. Proposed Insured

First Name	MI	Last Name (if applicable: Jr, Sr, ...)	Driver's License # / State of Issue

Social Security Number	Age	Sex	Date of Birth	United States Citizen? ☐ Yes ☐ No	Height	Weight

Telephone	Email Address

Street Address, City, State, Zip Code

2. Owner (if other than the Insured)

First Name	MI	Last Name	Driver's License # / State of Issue

Social Security or Tax ID Number	Age	Sex	Relationship to the Insured	Entity (i.e.: Non-Profit Organization) ☐ Yes* ☐ No

Telephone	Email Address

Street Address, City State, Zip Code

*Entities or Trusts must include the required documents acceptable to American Savings Life.

3. Beneficiary Information

Use the Additional Beneficiaries Form if necessary.

☐ PRIMARY **&** Percentage: _____%

Name_____

Street_____

City_____ State____ Zip_____

DOB_____ SSN_____

Relationship to Insured _____

☐ PRIMARY **or** ☐ CONTINGENT **&** Percentage: _____%

Name_____

Street_____

City_____ State____ Zip_____

DOB_____ SSN_____

Relationship to Insured _____

4. Insurance Product and Riders Applied for

Death Benefit Face Amount $ _____ ($5,000 to $250,000) *and* Premium Amount $ _____

☐ Check or ☐ Bank EFT Withdrawal or ☐ IRC Section 1035 Exchange (from a life insurance policy only, not an annuity)

Where are the funds coming from (Source of funds)?: _____

_____

The Chronic Illness Accelerated Death Benefit Riders (ALBR) will be included unless checked "No": ☐ No Chronic Illness ALBR.

The Terminal Illness Accelerated Death Benefit Riders (ALBR) will be included unless checked "No": ☐ No Terminal Illness ALBR.

5. Suitability and Medical Questions

☐Yes ☐No **1.** Do you believe that this life insurance policy is appropriate for your financial situation based on your income, net worth, funds, and retirement consideration?

☐Yes ☐No **2.** Do you have other sources of income to provide for your daily living needs and enough additional savings for emergency cash needs?

☐Yes ☐No **3.** In the past 12 months have you used nicotine in any form?

Part A: If any question in Part A is answered "Yes", the Proposed Insured is not eligible for coverage.

☐Yes ☐No **4.** Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living (ADL) such as dressing, eating, bathing, toileting, taking medications, or moving without any type of physical assistance?

☐Yes ☐No **5.** Are you currently using oxygen or breathing equipment to assist in breathing?

☐Yes ☐No **6.** Are you currently hospitalized, bedridden, receiving hospice or home health care**,** or have you been confined to a nursing home or assisted living facility in the last 6 months?

☐Yes ☐No **7.** Have you in the past 12 months been advised by a medical professional to have surgery, hospital confinement or nursing facility confinement and have not done so?

☐Yes ☐No **8.** Have you been hospitalized two or more times in the past 12 months?

In the past 12 months, have you been diagnosed with, treated for, or been advised by a medical professional to have treatment for:

☐Yes ☐No **9.** Chronic kidney disease, kidney (renal) failure or kidney (renal) insufficiency to include dialysis?

☐Yes ☐No **10.** Cirrhosis, liver failure, chronic hepatitis, or liver fibrosis?

☐Yes ☐No **11.** Cystic fibrosis, pulmonary fibrosis, respiratory failure or other chronic lung disorder?

☐Yes ☐No **12.** Internal cancer or melanoma, or have you ever had more than one occurrence of cancer or any metastasis (excluding basal or squamous cell skin cancer) in your lifetime?

☐Yes ☐No **13.** Angina, heart attack, heart disease, aneurysm or have you had a pacemaker, defibrillator, artificial heart valve, or had heart surgery such as angioplasty, stent placement, or bypass?

☐Yes ☐No **14.** Stroke, carotid artery disease, transient ischemic attack (TIA), circulatory disease, or had surgery to improve circulation to the heart, brain, or extremities?

☐Yes ☐No **15.** Diabetes requiring insulin by injection or pump and have you had as insulin shock, diabetic coma any diabetic complications (such as neuropathy, retinopathy or amputation)?

Within the past 24 months:

☐Yes ☐No **16.** Have you been treated, hospitalized or been advised by a medical professional to have treatment for alcoholism, excessive alcohol use, drug abuse including prescription medication, mental or nervous disorders such as schizophrenia, bipolar disorder, or attempted suicide?

☐Yes ☐No **17.** Have you been diagnosed, treated or been advised by a medical professional to have treatment for amyotrophic lateral sclerosis (ALS), cerebral palsy, Huntington's chorea, dementia, Alzheimer's, mental incapacity, organic brain syndrome, or paralysis of two or more extremities?

☐Yes ☐No **18.** Have you been told you have a terminal medical condition or end stage disease of any type expected to result in death within the next 24 months?

☐Yes ☐No **19.** In the last 2 years, have you been declined for life, health, or long-term care insurance?

☐Yes ☐No **20.** In the past 5 years, have you been convicted of a felony, incarcerated, been arrested or are you currently awaiting trial, sentencing, or are you currently on parole or probation?

☐Yes ☐No **21.** Have you ever been treated, hospitalized or been advised by a medical professional to have treatment for congestive heart failure, cardiomyopathy or have you had or been medically advised to have an organ transplant?

☐Yes ☐No **22.** Have you ever tested positive for exposure to the HIV infection, or been diagnosed as having ARC (AIDS-related complex) or AIDS (acquired immune deficiency syndrome) caused by the HIV infection or other sickness or condition derived from such infection?

Initial Here

Part B: If any question in Part B is answered "Yes", the Proposed Insured will be considered for a Substandard Policy.

1. Have you in the past 24 months been diagnosed, treated, or taken medication for:

☐Yes ☐No **a.** Lymphoma, Hodgkin's disease, melanoma, leukemia, or any internal cancer?

☐Yes ☐No **b.** Parkinson's disease, muscular dystrophy, multiple sclerosis, grand mal epilepsy, or systemic lupus?

☐Yes ☐No **c.** Emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis?

2. In the past 36 months, have you been diagnosed, treated, or taken medication for:

☐Yes ☐No **a.** Angina, heart attack, heart disease, or have you had a pacemaker, defibrillator, artificial heart valve, or had heart surgery such as angioplasty, stent placement or bypass?

☐Yes ☐No **b.** Stroke, carotid artery disease, transient ischemic attack (TIA), circulatory disease, or had surgery to improve circulation to the heart, brain, or extremities?

☐Yes ☐No **3.** In the last 3 years, have you been convicted of operating a vehicle while intoxicated, impaired or under the influence or for reckless driving or had your driver's license suspended or revoked?

☐Yes ☐No **4.** In the last 5 years, have you been diagnosed with, treated, or been advised to have treatment by a medical professional for alcohol abuse, drug abuse (prescription or non-prescription) or have you attempted suicide?

Attending Physician's name & address: _____

_____

If all questions in Parts A and B are answered "No", the proposed insured will be considered for a Standard policy.

6. Replacement Information

1. **EXISTING or APPLIED FOR INSURANCE:** Does the Proposed Insured have any existing life insurance or annuity contracts with this or any other company? ☐Yes ☐No

2. **REPLACEMENT:** In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction involving an annuity or other life insurance? ☐Yes ☐No

If Question 2 is answered Yes, complete and submit the American Savings Life required Replacement Form with this application.

7. Additional Ownership Questions

1. Has any party to the application, such as the applicant, or any beneficiary, entered or made plans to enter into any agreement or contract to sell or assign the ownership of, or a beneficial interest in the applied for policy? ☐Yes ☐No

2. Has any person promised or agreed to give or has given to any party to the application, or has any party to the application received or will receive from any person, any inducement, fee or compensation as an incentive to purchase the policy? ☐Yes ☐No

8. Declarations and Authorizations

PRIVACY NOTICE

At American Savings Life Insurance Company (We, Us, Our), We are committed to protecting your privacy and the confidentiality of your personal and financial information. We, like other insurance companies, sometimes evaluate the medical history and other personal information about Applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and career.) We also use this information to administer Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy; insurance support organizations; other insurance companies to which You have applied; and employers.

Initial Here

Any information You give Us regarding Your insurability and any information received from other sources will be treated as confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth, and phone number may also be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

If you wish, You have the right to request a copy of, items of personal information that appear in Our files. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT AMERICAN SAVINGS LIFE INSURANCE COMPANY, 935 E. MAIN STREET, MESA, AZ 85203, OR VISIT WWW.AMERICANSAVINGSLIFE.COM.

FAIR CREDIT REPORTING NOTICE

With regard to Your Application, We may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

MIB, INC. PRE-NOTICE – PROPOSED INSURED

Information regarding Your insurability will be treated as confidential. American Savings Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, that operates an information exchange on behalf of its members. If You apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply American Savings Life Insurance Company with the information in its file.

Upon receipt of a request from You, the MIB, Inc. will arrange disclosure of any information it may have in Your file. Please contact MIB, Inc. at 866-692-6901. If You question the accuracy of information in the MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc. is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. American Savings Life Insurance Company, or its reinsurers, may also release information in its file to MIB, Inc. and to other life or health insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

FRAUD NOTICE

Any person who knowingly submits a false statement in an Application or files a claim containing false or deceptive statements may be guilty of insurance fraud and subject to penalties under state law.

MISREPRESENTATION NOTICE

If your answers to the questions in this application are incorrect or untrue, American Savings Life Insurance Company may deny coverage by voiding or canceling your policy and returning your premium payments to you or your estate. Be aware that voiding or canceling your policy may have an adverse impact to your intended beneficiary(ies).

I have read, understand, and acknowledge the Misrepresentation Notice. I agree that the information on this application will be relied upon to determine insurability and that incorrect or untrue information may result in coverage being voided, subject to the Incontestability provision in the policy.

NOTICE OF MODIFIED ENDOWMENT CONTRACT (MEC)

Section 7702A of the Internal Revenue Code places a limit on the amount and timing of premium payments for a life insurance contract. If the limit is exceeded, the contract becomes a Modified Endowment Contract (MEC). Death benefits under a MEC are income tax free to the beneficiary. Any other value received from a MEC is referred to as a "distribution" and may result in an income tax liability. Distributions include cash withdrawals; cash surrender of the contract, loans, and assignment of the contract to another person or institution. Distributions are first considered to be any gain under the contract and the gain is taxable in the year that it is received. In addition, a taxable distribution is subject to a 10% tax penalty if the taxpayer has not attained age 59 ½, subject to certain exceptions contained in the tax code. Tax laws are subject to change. Neither American Savings Life Insurance Company, its affiliates, nor any of its representatives provide tax or legal advice. Individuals should consult their tax advisor or legal counsel for specific advice and information regarding their individual situation.

PROPOSED INSURED'S STATEMENT (or Owner, if Legal Representative)

I have read and understand this application. I am not currently taking any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this Application. The representations in this application are true. I agree the policy shall not be in effect until it has been issued by American Savings Life Insurance Company ("the Company") and the premium is paid. I understand that the Agent has no authority to approve this Application, change the policy, or waive any policy provisions. I understand no insurance will be effective until the date indicated in the policy and all eligibility requirements are met. The purpose of this Application is not to sell or assign it to any type of viatical settlement, senior settlement or life settlement company.

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy; pharmacy benefit manager; medical facility; insurance company; insurance support organization (such as MIB, Inc. or any of its members or affiliates); or other health care provider that has provided payment, treatment, or services to me or on my behalf (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me to the company referenced on this authorization ("the Company") and their Producers; employees; and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol; drugs; and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction for use in underwriting risk selection purposes.

This protected health information can be disclosed under the authorization at my request, as permitted by §164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule"). This authorization will remain in force for 36 months following the date of my signature below, regardless of my condition and whether living or deceased, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company (Attention: American Savings Life Insurance Company, 935 E. Main Street, Mesa, AZ 85203). I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record the Company may not be able to process my Application; or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

MEDICAL AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical care facility, the Veteran's Administration, insurance company, MIB, Inc., pharmacy, pharmacy benefit manager, insurance laboratories, my employer or consumer reporting agency, to give American Savings Life Insurance Company or its reinsurers any information they have about my health, including confidential HIV-related information. I authorize American Savings Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. I acknowledge receipt of the MIB, Inc. Pre-Notice. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies. I agree that a copy of this authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for use in underwriting risk selection purposes only and is valid for 36 months, except for HIV-related information, which is only valid for 180 days from the date below.

Application made at _____ (City, State)

Date _____ (Month/Date/Year)

X _____
Signature of Proposed Insured

_____
Signature of Owner (If other than Proposed Insured)

_____
Signature of Licensed Insurance Agent

_____
Owner's Title if signed on behalf of an entity, trust, etc.

9. Agent Certification

I certify that I have asked the person proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the person proposed for coverage.

a. Did you verify the identity of the applicant by viewing their driver's license or other government issued form of identification? ..... ☐Yes ☐No

b. Do you have knowledge or reason to believe that replacement of existing life insurance or annuity policies may be involved? ..... ☐Yes ☐No

c. If replacement is occurring, do you certify that this replacement complies with American Savings Life Insurance Company's replacement guidelines? ..... ☐Yes ☐No ☐Not Applicable

I certify that only advertising previously approved by American Savings Life Insurance Company was used in conjunction with this sale, and that copies of all sales materials used in this sale have been left with the applicant. Any electronically presented sales materials will be provided in printed form to the applicant no later than at the time of policy delivery.

Based on the information disclosed to me by the applicant, my recommendation of a Single Premium Whole Life insurance policy is reasonably suited to fulfil the applicant's needs. I have recorded the applicant's needs analysis information, which formed the basis for my recommendation, and I will make this information available to American Savings Life Insurance Company upon request.

I certify that the above statements and responses are true and accurate.

x _____

Agent Signature | Agent Printed Name | Agent Number | Date

The policy will be mailed directly to the Policyowner unless indicated otherwise: ❑ Mail to Agent for delivery to Policyowner.

Split Credit: If there will be a commission split on this application, both agents will need to be indicated. Otherwise 100% of the commission will be paid to the primary agent of record (i.e.: agent who signed the application). Both must be contracted agents.

Secondary Agent: _____ Agent #: _____ Split credit _____%

Agent Comments:

_____

_____

_____

_____

This original signed application and any other applicable original signed forms would need to be sent to: American Savings Life Insurance Company, Suite 100, 935 E. Main Street, Mesa, Arizona 85203-8849.

Once received at the ASL Home Office, an underwriting interviewer will call the Proposed Insured in order to briefly review the application questions (approximately 15 minutes) on a recorded line.

There is no conditional or temporary insurance receipt with this application.

IMPORTANT NOTICES REQUIRED TO BE LEFT WITH THE APPLICANT & OWNER AT TIME OF APPLICATION

PRIVACY NOTICE

At American Savings Life Insurance Company (We, Us, Our), We are committed to protecting your privacy and the confidentiality of your personal and financial information. We, like other insurance companies, sometimes evaluate the medical history and other personal information about Applicants to determine their eligibility for certain policies. (Personal information includes information such as age, occupation, physical condition, health history, habits, general reputation, credit and career.) We also use this information to administer Your insurance coverage after it is in force.

We rely heavily on information provided by You. We may also supplement this information from other sources, such as medical professionals or institutions that have treated You or family members covered under Your policy; insurance support organizations; other insurance companies to which You have applied; and employers.

Any information You give Us regarding Your insurability and any information received from other sources will be treated as confidential. In some situations, and in compliance with applicable law, We may disclose necessary items of information to third parties, who may retain a copy and disclose the information to others for whom they perform such services, without Your specific authorization. Unless You request otherwise, Your name, address, date of birth, and phone number may also be used by Us or Our affiliates to inform you of other insurance products or services which are available. We may also disclose this information to: (1) an organization performing administrative, business or professional services for Us; (2) other insurance companies to which You apply; and (3) your physician or medical professional.

If you wish, You have the right to request a copy of, items of personal information that appear in Our files. You also have the right to seek correction of information you believe to be inaccurate.
THE ABOVE IS A GENERAL DESCRIPTION OF OUR PRIVACY PRACTICES. IF YOU WOULD LIKE A MORE DETAILED EXPLANATION OF OUR PRACTICES AND THE CIRCUMSTANCES UNDER WHICH WE MAY USE OR DISCLOSE INFORMATION, PLEASE WRITE TO OUR PRIVACY OFFICER AT AMERICAN SAVINGS LIFE INSURANCE COMPANY, 935 E. MAIN STREET, MESA, AZ 85203, OR VISIT WWW.AMERICANSAVINGSLIFE.COM.

FAIR CREDIT REPORTING NOTICE

With regard to Your Application, We may have requested an investigative consumer report. These reports contain information about Your character, general reputation, mode of living and health except as may be related directly or indirectly to Your sexual orientation. The information may have been obtained through interviews with You, Your neighbors, friends and others who know You. Upon request, We will give You the name and address of the consumer reporting firm so that You may request a copy of the report.

MIB, INC. PRE-NOTICE – PROPOSED INSURED

Information regarding Your insurability will be treated as confidential. American Savings Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, that operates an information exchange on behalf of its members. If You apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply American Savings Life Insurance Company with the information in its file.
Upon receipt of a request from You, the MIB, Inc. will arrange disclosure of any information it may have in Your file. Please contact MIB, Inc. at 866-692-6901. If You question the accuracy of information in the MIB, Inc.'s file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc. is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734. American Savings Life Insurance Company, or its reinsurers, may also release information in its file to MIB, Inc. and to other life or health insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

STRANGER OWNED LIFE INSURANCE (STOLI) NOTICE

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

NOTICE OF MODIFIED ENDOWMENT CONTRACT (MEC)

Section 7702A of the Internal Revenue Code places a limit on the amount and timing of premium payments for a life insurance contract. If the limit is exceeded, the contract becomes a Modified Endowment Contract (MEC). Death benefits under a MEC are income tax free to the beneficiary. Any other value received from a MEC is referred to as a "distribution" and may result in an income tax liability. Distributions include cash withdrawals; cash surrender of the contract, loans, and assignment of the contract to another person or institution. Distributions are first considered to be any gain under the contract and the gain is taxable in the year that it is received. In addition, a taxable distribution is subject to a 10% tax penalty if the taxpayer has not attained age 59 ½, subject to certain exceptions contained in the tax code. Tax laws are subject to change. Neither American Savings Life Insurance Company, its affiliates, nor any of its representatives provide tax or legal advice. Individuals should consult their tax advisor or legal counsel for specific advice and information regarding their individual situation.