The Youth Life Insurance Plan

Youth Life Insurance Plan - Application

American Savings Life Insurance Company
935 E. Main Street, Mesa, Arizona 85203-8849
(480) 835-5000 | (800) 880-2112
www.AmericanSavingsLife.com

Children's Whole Life Insurance with the optional Guaranteed Interest Account Rider

Youth Life Insurance Plan with the optional Guaranteed Interest Account (GIA)					
Youth Life Insurance Plans	Child's Health Condition	Annual Premium is set by child's Issue Age			GIA Maximum Account Balance
		15 days - 8 yrs	9 - 13 yrs	14 - 17 yrs	
$20,000 Standard Benefit	Includes mild/moderate conditions	$100	$120	$140	$20,000
$10,000 Standard Benefit	Includes mild/moderate conditions	$50	$60	$70	$10,000
$5,000 Standard Benefit	Includes mild/moderate conditions	$25	$30	$35	$5,000

Age bracket determines premium amount which will never increase. Monthly premiums also available (just divide annual premium by 12).

Guaranteed Interest Account (GIA):	☐ **Yes, open a GIA.** ☐ **No, do not open a GIA.** ☐ **A GIA previously has been established: _____.**

All Owners and all Proposed Insureds must be United States citizens. All Owners must be residents of either Arizona or Utah.

Policy Owner - Owner(s) must be age 18 or older. If Ownership is a Trust, include the Trust Certification Form.

Name (If Owner is a Trust, indicate Name, Date and Tax ID # of Trust)	Gender	Date of Birth	Social Security Number / TIN

Mailing Address

Relationship to the Proposed Insured*	Telephone number	Email Address

Joint Policy Owner (If applicable): ☐ Check box if **both** owners signatures are required for **all** authorizations (including GIA); otherwise only one signature will be required.

Name	Relationship to the Proposed Insured*	Gender	Date of Birth	Social Security Number

***Insurable Interest:** Parent (including adopted children, but not foster children), Grandparent, Legal Guardian.

Proposed Insured(s) - Must be between ages 15 days through 17 years old (age last birthday)

Name	Gender	Date of Birth	Social Security Number	Height	Weight	Youth Life Insurance Plan Choice:
1.)						☐**$20,000** ☐**$10,000** ☐**$5,000**
2.)						☐**$20,000** ☐**$10,000** ☐**$5,000**
3.)						☐**$20,000** ☐**$10,000** ☐**$5,000**
4.)						☐**$20,000** ☐**$10,000** ☐**$5,000**
5.)						☐**$20,000** ☐**$10,000** ☐**$5,000**

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Application Questions (Answer all questions for all indicated Proposed Insureds)					
If Yes to any question, provide details in the below Comments section (condition, results, dates, prescriptions taking, physician contact information).	**Proposed Insured # 1**	**Proposed Insured # 2**	**Proposed Insured # 3**	**Proposed Insured # 4**	**Proposed Insured # 5**
Within the past 5 years, has the Proposed Insured received any medical advice, treatment or examination (other than a normal routine wellness exam with no negative results)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Within the past 5 years, has the Proposed Insured been advised by a member of the medical profession to get specified medical care which was not completed, such as but not limited to hospitalization, surgery or diagnostic test?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Does the Proposed Insured currently take any prescription drugs or have any existing impairments, diseases, health or medical conditions?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

"Yes" answer comments (condition, results, dates, prescriptions taking, physician information): _____

_____

_____

_____

Replacement Information (Answer all questions for all indicated Proposed Insureds)					
If Question 2 is answered Yes, submit the required Replacement Form with this application.	**Proposed Insured # 1**	**Proposed Insured # 2**	**Proposed Insured # 3**	**Proposed Insured # 4**	**Proposed Insured # 5**
1. Does the Proposed Insured have any existing or applied for life insurance or annuity contracts with this or any other company?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
2. In connection with this application, has there been, or will there be, with this or any other company any surrender, loan, withdrawal, lapse, reduction or redirection of premium/consideration or change involving an annuity or other life insurance?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Beneficiary Information: ☐ **Check box if Policy Owner(s) will be Primary Beneficiary(ies), otherwise list below or use the Beneficiary Addendum Form.**	
Name(s)	Relationship(s) to the Proposed Insured
Mailing Address	Telephone number

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Children's Whole Life Insurance

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.

ACKNOWLEDGMENT AND AUTHORIZATION

In providing the premium shown on this application for the Proposed Insured, I understand that the insurance applied for will not become effective until the date that this application is approved by the Home Office of American Savings Life Insurance Company. This is not a guaranteed issue product and there is no conditional receipt.

I represent that my above answers are true and complete to the best of my knowledge and belief, and I am fully aware of the Proposed Insured's medical condition and application responses. This information was provided by the Proposed Insured's parent or legal guardian. I understand that this application shall be the basis for and a part of the life insurance policy.

Application made at _____ dated on _____
(City, State) (Month/Date/Year)

X_____ X_____
Signature of Owner Signature of Joint Owner (If applicable)

X_____
Signature of Proposed Insured's Parent/Legal Guardian (if not the Owner) Parent's/Guardian's Printed Name Date

_____
Life Insurance Agent Signature (if applicable) Life Insurance Agent Printed Name ASL Agent Number Date

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

Comments: _____

_____

_____