FINAL EXPENSE

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595 • (254) 297-2775

LIFE INSURANCE APPLICATION (Please print in black ink) **Telephone Case No:**_____

Proposed Insured _____ (First) (Middle) (Last)
Address (No. & Street)_____
City State Zip Code

Telephone interview completed ☐ Yes ☐ No
_____ Phone _____ Best time to call ☐ am ☐ pm
E-mail Address

☐ Male ☐ Female	Date of Birth / /	Age	State of Birth	Social Security Number / /	Height ft in	Weight lbs

Owner: Name_____Relationship_____SS#_____ /____/_____
Address City/State/Zip

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Plan: _____ **Face Amount of Insurance $**_____
☐ Immediate Death Benefit
☐ Graded Death Benefit (Percentage of Face Amount)
☐ Return of Premium Death Benefit

☐ Check here if you are willing to accept any plan for which you qualify based on this application. The insurance for which you qualify may have a graded or return of premium death benefit for the first two (2) or three (3) years, a face amount less than any indicated on this application, and riders may not be available.

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No

Rider: ☐ Grandchild/Great Grandchild Coverage ____ Number of Children Applying ____ Units ☐ Other _____
☐ Child Rider* Units ☐ ADB* Amt $ (*not available on Return of Premium Death Benefit)
Automatic Premium Loan Elected? ☐ Yes ☐ No

Mode: ☐ Bank Draft ☐ Draft 1st Prem on Req. Date ☐ Other Modal Prem $
CWA: ☐ E-Check Immediate 1st Prem ☐ Collected $
Mail Policy To: ☐ Agent ☐ Insured ☐ Owner
Requested Policy Date: / /

A. Do you have existing life insurance or an annuity contract? ☐ Yes ☐ No
B. Will you replace an existing life insurance policy or an annuity? ☐ Yes ☐ No
Company
Policy # Amount of Coverage $

Physician Name: City/State: Phone:

HEALTH INFORMATION

1. Are you currently hospitalized, confined to a nursing facility, a bed, or a wheelchair due to chronic illness or disease, currently using oxygen equipment to assist in breathing, receiving Hospice Care or home health care, or had an amputation caused by disease, or do you currently have any form of cancer (excluding basal cell skin cancer), or do you require assistance (from anyone) with activities of daily living such as bathing, dressing, eating or toileting? ..... ☐ Yes ☐ No
2. Have you had or been medically advised to have an organ transplant or kidney dialysis, or have you been medically diagnosed as having congestive heart failure (CHF), Alzheimer's, dementia, mental incapacity, Lou Gehrig's disease (ALS), liver failure, respiratory failure, or any terminal illness or end-stage disease? ..... ☐ Yes ☐ No
3. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder (excluding HIV status) or tested positive for the Human Immunodeficiency Virus (HIV) limited in scope to prior testing for the purpose of obtaining insurance? ..... ☐ Yes ☐ No

If any answer to questions 1 through 3 is answered "Yes" the Proposed Insured is not eligible for any coverage.

4. Have you ever been medically diagnosed or treated for complications of diabetes, including insulin shock, diabetic coma, retinopathy (eye), nephropathy (kidney), neuropathy (nerve damage/pain), or used insulin prior to age 50? ..... ☐ Yes ☐ No
5. Have you ever been medically diagnosed, treated or taken medication for renal insufficiency, kidney failure, chronic kidney disease, or more than one occurrence of cancer in your lifetime (excluding basal cell skin cancer)? ..... ☐ Yes ☐ No
6. Within the past 2 years have you had any diagnostic testing (excluding tests related to Human Immunodeficiency Virus (HIV)), surgery, or hospitalization advised by a medical professional which has not been completed or for which the results have not been received? ..... ☐ Yes ☐ No
7. Within the past 2 years have you:
   a. been medically diagnosed or treated for angina (chest pain), stroke or TIA, cardiomyopathy, systemic lupus (SLE), cirrhosis, Hepatitis C, chronic hepatitis, chronic pancreatitis, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, or required oxygen equipment to assist in breathing? ..... ☐ Yes ☐ No
   b. had a heart attack or aneurysm, or had or been medically advised to have any type of heart, brain or circulatory surgery (including, but not limited to a pacemaker insertion, defibrillator placement), or any procedure to improve circulation? ..... ☐ Yes ☐ No
   c. been medically diagnosed, or treated, or taken medication for any form of cancer (excluding basal cell skin cancer)? ..... ☐ Yes ☐ No
   d. used illegal drugs, abused alcohol or drugs, had or been recommended by a medical professional to have treatment or counseling for alcohol or drug use or been advised to discontinue use of alcohol or drugs? ..... ☐ Yes ☐ No

If any answer to questions 4 through 7 is answered "Yes" the Proposed Insured should apply for the Return of Premium Death Benefit Plan.

8. Within the past 3 years have you been medically diagnosed or treated, or hospitalized for:
   a. stroke, angina (chest pain), heart attack, aneurysm, heart or circulatory surgery or any procedure to improve circulation? ... ☐ Yes ☐ No
   b. or taken medication for any form of cancer (excluding basal cell skin cancer), emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), ulcerative colitis, cirrhosis, Hepatitis C, or liver disease? ..... ☐ Yes ☐ No
   c. paralysis of two or more extremities or any neuro-muscular disease or disorder (including, but not limited to cerebral palsy, multiple sclerosis, seizures, or Parkinson's disease)? ..... ☐ Yes ☐ No

If any answer to question 8 is answered "Yes" the Proposed Insured should apply for the Graded Death Benefit Plan.

If all questions 1 through 8 are answered "No" the Proposed Insured should apply for the Immediate Death Benefit Plan.

Form No. OL9466-CA(Rev.1/15)

NOTICE
Printed in compliance with Public Law 91-508

Thank you for considering Occidental Life Insurance Company of North Carolina for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. Occidental Life Insurance Company of North Carolina, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of life insurance companies, which 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, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. If you question the accuracy of information in 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.'s information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Occidental Life Insurance Company of North Carolina, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com.

CHILD, GRANDCHILD, AND GREAT GRANDCHILD COVERAGE - Children Proposed for Insurance (list additional children on a separate sheet):

Proposed Insured Name	Sex	Birthdate	Relationship	Proposed Insured Name	Sex	Birthdate	Relationship

PROPOSED CHILDREN'S HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months. List the names of children that are exceptions to PROPOSED CHILDREN'S HEALTH STATEMENT.

Children listed as an exception are excluded from the appropriate Child Rider Coverage. Exceptions are:_____

AGREEMENT—I agree with Occidental Life Insurance Company of North Carolina (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the MIB, Inc. or inspection company that has knowledge or records of me and my health to give such information to: (a) Occidental Life Insurance Company of North Carolina; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the MIB, Inc., are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize Occidental Life Insurance Company of North Carolina to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the MIB, Inc.; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, the MIB, Inc. Pre-Notice and the Terminal Illness Accelerated Benefit Rider Disclosure Form.

Signed at _____ Date of Application _____
CITY STATE MONTH DAY YEAR

_____ _____
SIGNATURE OF PROPOSED INSURED SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED)

AGENT'S REPORT

Does the proposed insured have any existing life insurance or annuity contract? ..... ☐ Yes ☐ No
Is the proposed insurance intended to replace or change any existing life insurance or annuity? ..... ☐ Yes ☐ No

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature.

I certify that the Terminal Illness Accelerated Benefit Rider Disclosure Form has been presented to the applicant.

AGENT'S REMARKS:_____

_____ _____ _____ _____
AGENT'S PRINTED NAME DATE AGENT'S PRINTED NAME DATE

Agent _____ No: _____% _____ Agent _____ No: _____% _____
SIGNATURE SIGNATURE

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____ Account Holder_____

Financial Institution_____ Address_____

Transit/ABA Number_____ Account Number_____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)_____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of Occidental Life Insurance Company of North Carolina, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization 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.

_____ _____
SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS) DATE

Form No. OL9466-CA(Rev.1/15)

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
P.O. BOX 2595, WACO, TX 76702-2595

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of_____ the sum of $_____ as first payment on this application.

Date_____ Agent_____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $30,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

Occidental Life Insurance Company of North Carolina

Please note charge may appear on statement under American-Amicable Group of Companies

P.O. Box 2549 Waco TX 76702-2549

Policy Number _____

Bank Draft Authorization - Please Attach a Voided Check.

The Company indicated above is authorized to initiate debit entries to the account indicated below, and the Bank named below is authorized to debit the same to such account. This authority can be terminated by the undersigned at any time by written notification to the Company, provided only that the Company and the bank will have a reasonable opportunity to act on such notification. By signing below, I authorize the Company indicated above and/or their representative to receive information from the banking facility named so my account number and routing number may be verified.

Bank Name _____

Bank Address _____

Transit/ABA Number _____ **Account Type:** ☐ Checking ☐ Savings

Account Number _____ **Amount $** _____

Would you like your draft to coincide with your Social Security payment schedule? ☐ Yes ☐ No

Please choose one of the following as your requested draft date (applies to first and future drafts of this account):

☐ Requested Draft Date, If Any (1st-28th) _____ OR ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

_____	_____	_____
PRINT NAME	**SIGNATURE (AS ON FINANCIAL INSTITUTION RECORDS)**	**DATE**

Bank Account Verification - Complete ONLY in absence of void check.

I have verified that the above account is a valid account and can be drafted for insurance premiums. I understand that if the information provided is found to be falsified, I may be subject to disciplinary action up to and including termination of my agent contract. This information was verified by a verification call with a bank representative.

Please provide the phone number and name of the person you spoke to at the Bank:_____

_____	_____
AGENT SIGNATURE / AGENT NUMBER	**DATE**

By signing below, I authorize the Company indicated above and/or one of their representatives to receive information from the banking facility named above so my banking information can be verified.

_____	_____
SIGNATURE (of bank account holder)	**DATE**

E-Check Bank Draft Authorization
COMPLETE THIS SECTION TO IMMEDIATELY DRAFT PREMIUM

Immediately upon receipt of My Application, please draft $_____ from my account listed above and identified with a void check, deposit slip, bank statement or Bank Account Verification above.

_____	_____
SIGNATURE	**DATE**

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
Occidental Life Insurance of North Carolina (here after referred to as the Company)

This Authorization complies with the HIPAA Privacy Rules

The Authorization must be fully completed as a condition of obtaining coverage. A refusal to sign this authorization will result in a rejection of your application for the insurance. A copy of this authorization will be considered as valid as the original.

1. I hereby authorize the following person(s) or group of persons to disclose information to the company: Any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans.

2. This authorization specifically includes the release of **all medical records** including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS.

3. Person(s) or group of persons authorized to receive and use the information: The Company and its business associates and those persons or entities providing services to the Company plans.

4. The information will be used to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any material omission(s) or misrepresentation(s) in my application.

5. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave, Waco TX 76701.

7. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

8. This authorization will expire 24 months after the date signed.

Signature of Proposed Insured who is Age 18 and over, Parent (on behalf of a minor) or Legal Representative:

Proposed Insured:_____ Date:_____

Spouse (if applicable):_____ Date:_____

Signature of minor's parent or legal guardian:_____ Date:_____

CALIFORNIA RESIDENTS
RIGHT TO DESIGNATE A THIRD-PARTY
TO RECEIVE NOTICE OF LAPSE OR TERMINATION

You are being provided this notice pursuant to California Insurance Code 10113-72(a). You have the right to designate a third-party to receive a notice of lapse or termination of your life insurance policy due to nonpayment of premium. You may make such designation at the time of application or at any time the life insurance policy is in force by submitting a written notice to the Company containing the name and address of the third-party designee. You may change your designation at any time with written notice to the Company.

Please indicate your choice by completing the information below.

_____ I designate the following person to receive any notice regarding the lapse or termination of my life insurance policy due to nonpayment of premium:

(Please Print)

Name of Person to Receive Notice _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ E-Mail Address _____

OR

_____ I elect *NOT* to designate another person to receive notice of lapse or termination of my life insurance policy for nonpayment of premium at this time.

Signature of Owner _____ Date _____

IF RETURNING THIS FORM PLEASE COMPLETE THE FOLLOWING:

Name of Insured: _____

Policy Number: _____

Social Security Drafting

Drafting Along with Social Security

In order to match up the drafts to coincide with your client's receipt of Social Security payments, use the following **"Requested Draft Days"** when completing the bank draft authorization:

- **1S** - if Social Security is received on the 1st
- **3S** - if Social Security is received on the 3rd
- **2W** - if Social Security is received on the 2nd Wednesday
- **3W** - if Social Security is received on the 3rd Wednesday
- **4W** - if Social Security is received on the 4th Wednesday

Please Note: If you enter simply a **"1"** for the 1st or **"3"** for the 3rd, the drafts will not necessarily follow along with Social Security.

Example:
Let's say the 1st falls on a Saturday, the following shows the timing of drafts based upon the draft day you have entered:

- **1S** - We will draft for premiums on the Friday before. This matches the timing of the Social Security funding calendar.

- As opposed to -

- **1** - We will draft for premiums on the Monday after.

The use of these special draft dates for Social Security have greatly reduced the number of return drafts for NSF.

AMERICAN-AMICABLE LIFE INSURANCE COMPANY OF TEXAS

3492

iA Financial Group

PRIVACY NOTIFICATION FOR THE INDUSTRIAL ALLIANCE GROUP – US OPERATIONS

If you have some form of disability that makes it difficult for you to use this document, you may access this information in an alternative format at: www.iaamerican-waco.com.

The Industrial Alliance Group-U.S. Operations is composed of Industrial Alliance Insurance and Financial Services Inc.'s U.S. Branch and Industrial Alliance Insurance and Financial Services Inc.'s U.S. subsidiaries, including but not limited to IA American Life Insurance Company, American-Amicable Life Insurance Company of Texas, Occidental Life Insurance Company of North Carolina, Pioneer American Insurance Company, Pioneer Security Life Insurance Company and Industrial Alliance Portfolio Management (U.S.) LLC (the "Company"). The Company is committed to protecting the Company's clients', employees' and representatives' (the "Individual/s") privacy, and to ensuring the confidentiality of the personal information provided to it in the course of the Company's business.

The Company's Privacy Policy sets out the Company's standards for collecting, using, disclosing and storing your personal information. The Company's Privacy Policy also explains how the Company safeguards your personal information and the individual's right to access that information. The Privacy Policy is located at: www.iaamerican-waco.com.

The purpose of this notice is to inform you at or before the time of collection of your personal information of the categories of personal information that will be collected from you and the purposes for which these categories of personal information will be used.

We will not use your personal information for any purpose other than those disclosed in this notice. In the event that in the future we determine it is necessary to use your personal information for a purpose that was not previously disclosed to you, we will directly notify you of this new use and obtain explicit consent from you to use your information for this new purpose.

We will be collecting the following categories of personal information about you:

Categories of Personal Information	Categories of Sources	Commercial Purpose	Third Parties With Whom Business Shares Informationy	Third Parties to Whom Business Sells Information
Personally Identifiable Information, including, but not limited to, name, SSN, financial information, address, phone number, geolocation data, signature, height, weight, insurance policy number, health insurance information, health data, passport, driver's license	Application Premium Accounting Claims Forms	Application processing Claims processing Premium processing Benefit payment processing Accounting Legal Audit	Information Verification Organizations Medical Facilities	None
Protected Classes, including, but not limited to, race, citizenship, national origin, military status, religion, sex, gender identity expression, medical condition or disability, marital status, age, genetic information	Application Claims Forms	Application processing Claims processing Premium processing Benefit payment processing Accounting Legal Audit	Information Verification Organizations Medical Facilities	None
Internet or Other Electronic Network, including, but not limited to, online identifiers, e-mail address, account name, search history, browsing history, cookie data, IP address, online interactions (web sites, applications, and advertisements)	Application Claims	Application processing Claims processing	Information Verification Organizations Medical Facilities	None
Behavioral and Profiling Data	Application Claims	Application processing Claims processing	Information Verification Organizations Medical Facilities	None
Professional, Employment, and Education	Application Claims	Application processing Claims processing	Information Verification Organizations Medical Facilities	None
Sensory Data	Application Claims	Application processing Claims processing	Information Verification Organizations Medical Facilities	None

OCCIDENTAL LIFE INSURANCE COMPANY OF NORTH CAROLINA
PO Box 2549 Waco, Texas 76702-2549

Addendum to Application for COVID-19

Proposed Insured's Name (Please Print):_____

Within the past 12 months, have you been medically treated for, diagnosed for, or tested positive for the novel coronavirus (COVID-19)?..... ☐ Yes ☐ No

This Addendum to Application amends and is made a part of my individual life insurance application. To the best of my knowledge and belief, all answers and statements contained in this application are true, complete, and correctly recorded. I will notify the Company of any changes in the statements or answers given in this application between the time of application and delivery of the policy.

Fraud Notice: The falsity of any statement in this application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affects the acceptance of the risk or the hazard assumed by the Company.

Signed at_____ Application Date_____
(City and State)

Signature of Proposed Insured_____

Signature of Owner (If other than Proposed Insured)_____

☐ American-Amicable Life Insurance Company of Texas
☐ IA American Life Insurance Company
☐ Occidental Life Insurance Company of North Carolina
☐ Pioneer American Insurance Company
☐ Pioneer Security Life Insurance Company

P.O. Box 2549 • Waco, TX 76702-2549

Important Notice: Any person who meets with a senior (ages 65 and older) in the senior's home is required to deliver a notice in writing to the senior no less than 24 hours and no more than 14 days prior to that individual's initial meeting in the senior's home. If the senior has an existing insurance relationship with an agent and requests a meeting with the agent in the senior's home the same day, a notice shall be delivered to the senior prior to the meeting.

Appointment date (month/day/year): ___/___/___ Appointment Time:_____AM / PM

SALE OF LIFE INSURANCE AND ANNUITIES TO SENIORS IN CALIFORNIA

1. I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following (indicate all that apply):
   ☐ Life insurance, including annuities
   ☐ Other insurance products (please specify): _____
   _____
2. You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.
3. You have the right to end the meeting at any time.
4. You have the right to contact the Department of Insurance for information or to file a complaint. The consumer assistance telephone number at the California Insurance Department is 1-800-927-4357 or 213-897-8921.
5. The following individuals will be coming to your home:

Attendee's Name: _____ California Insurance License No.
Mailing Address: _____ (if applicable): _____
_____ Telephone No.: _____

Attendee's Name: _____ California Insurance License No.
Mailing Address: _____ (if applicable): _____
_____ Telephone No.: _____

Attendee's Name: _____ California Insurance License No.
Mailing Address: _____ (if applicable): _____
_____ Telephone No.: _____

Agent's Signature: _____ Date (month/day/year):___/___/___

By signing this form, I certify that this notice was delivered to me no less than 24 hours and no more than 14 days prior to the meeting time shown at the top of this form or was provided to me prior to the meeting if the agent has an existing relationship with me.

Client's Signature: _____ Date (month/day/year):___/___/___

Form No. 9555(12/12) 1 Copy - Home Office / 1 Copy - Applicant

Occidental Life Insurance Company of North Carolina
P.O. Box 2549 • Waco, Texas 76702-2549

NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITY

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way, you can be sure you are making a decision that is in **your** best interest.

We are required by law to notify your existing company that you may be replacing their policy.

List below the identification of policies which are involved in the replacement transaction.

Insured's Name	Company	Contract Number

Applicant's Signature	Date	Agent's Signature

1 Copy - Applicant / 1 Copy - Home Office