INDIVIDUAL LIFE INSURANCE
APPLICATION DEADLINE: MONTH 00, 2011

Amica Simplified Life Application

1. Applicant Information *Please print in ink.*

John Doe
23 New Road
Anytown, ST 12345

Phone Number: (_____) _____
❑ Home ❑ Cell ❑ Work

Email Address: _____

Date of Birth: _____ Gender: _____

Height and Weight: _____

Social Security No.: _____ Driver's License No.: _____

Coverage Amount Requested
Please check one.
☐ **$50,000** ☐ **$100,000**
☐ **$150,000** ☐ **$200,000**

Term Period
Please check one.
☐ **10 years** ☐ **15 years** ☐ **20 years**

2. Simplified Questions *Please check YES or NO for each question.*

On the back page of this application, please provide full details for any questions answered "YES" (except number 2). List doctor(s) and date(s) of onset, along with types of treatment, medicine and dosage.

1. Do you plan residence or travel outside the USA within the next two years?
❑ YES ❑ NO

2. Are you a U.S. citizen or a U.S. resident that holds a permanent visa?
❑ YES* ❑ NO
** If you are a U.S. resident with a permanent visa, please provide:* _____
Visa Number *Expiration Date*

3. In the last 12 months have you smoked one or more cigarettes or cigars, or a pipe, or used tobacco or nicotine (or nicotine substitutes) in any form?
❑ YES ❑ NO

4. In the past 2 years, have you been hospitalized or evaluated in an emergency room or immediate care center for any chronic illness requiring ongoing treatment or care by a physician?
❑ YES ❑ NO

5. Are you awaiting a diagnosis or within the last five (5) years been advised to have a surgical operation, a diagnostic test or evaluation that has not yet been completed?
❑ YES ❑ NO

6. In the past 10 years, have you received any treatment, medical advice, consultation or been diagnosed by a member of the medical professions for: diabetes; cancer (excluding basal cell or squamous cell carcinoma of the skin); stroke or transient ischemic attack (TIA); emphysema; chronic bronchitis; chronic lung disease; depression; bipolar disease or mood disorder; schizophrenia; Alzheimer's disease; dementia; degenerative muscle or nerve disease/disorder; paralysis; lupus; rheumatoid arthritis; alcohol or drug abuse; or any disease or disorder of the following: heart, aorta, coronary arteries, peripheral vascular system, blood, liver, pancreas, kidney, brain, or connective tissue?
❑ YES ❑ NO

7. Have you been diagnosed as having AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)?
❑ YES ❑ NO

8. In the past 3 years, has your driver's license been suspended or revoked, or have you been convicted of or pled "guilty" or "no contest" to any felony or DWI/DUI, or are you in prison or serving a probation/parole program?
❑ YES ❑ NO

(Continued on other side)

9. In the past 2 years, have you participated in mountain or rock climbing, bungee jumping, sky diving, scuba diving, flying a plane, or racing of powered air, water, or land vehicles?
❑ YES ❑ NO

10. In the past year, have you experienced unintentional weight loss?
❑ YES ❑ NO

NOTE: Please review your answers to these questions to be sure you have answered them fully and truthfully. A misrepresentation on these questions could void your coverage.

Beneficiary Designation *Note: All beneficiaries in a class share equally unless otherwise noted.*

PRIMARY Beneficiary Full Name	Relationship	
Contingent Beneficiary Full Name	Relationship	%
Contingent Beneficiary Full Name	Relationship	%

3. Acknowledgements and Signature *Please read and sign.*

1. Do you have any existing life insurance policies or annuity contracts in force?
❑ YES ❑ NO

2. If so, is the insurance applied for intended to replace or change any existing life insurance or annuity contracts in force with an insurance company?
❑ YES ❑ NO

Please supply company name and policy number being replaced if answered "Yes."

Company _____ *Policy Number* _____

I acknowledge: that I have read this application and all the statements and answers contained herein; and that they are complete and true to the best of my knowledge and belief. I understand that such statements and answers will be used by Amica Life to determine eligibility for insurance; and that no additional information regarding such statements and answers will be considered to have been given to Amica Life unless such information is stated in this application.

I understand: that no policy is effective until this application has been approved; a policy has been issued by Amica Life and accepted by the Owner; and the entire amount of the first modal premium has been received and accepted by Amica Life while the Insured is alive. I also understand that a sales representative does not have authorization to: accept risk; rule on insurability; or make, void, waive or change any conditions or provisions of this application or of any receipt or policy issued by Amica Life.

I acknowledge that I have read and received "How Your Amica Life Application is Processed to Protect Your Rights," required by the Federal Fair Credit Reporting Act and the Medical Information Bureau (MIB). I authorize any: physician; medical professional; hospital, clinic or other medical care institution; the MIB; insurer consumer reporting agency; other insurance company; pharmacy benefits manager; or any other organization, institution or person that has any records or knowledge of me or my health; to provide information to Amica Life Insurance Company, its representative, or any consumer reporting agency acting on Amica Life's behalf. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by Amica Life to collect and transmit such information. I also authorize Amica Mutual Insurance Company to provide personal information to Amica Life Insurance Company to assist Amica Life Insurance Company in obtaining information and reports necessary to process this application.

I understand that a photographic copy or facsimile (or transmission by other electronic means) of this statement shall be as valid as the original. I know that my authorized representative or I have the right to receive a copy of this statement upon request.

I agree this authorization is valid for two and one-half (2½) years from the date signed. A consumer report may be obtained; if such a report is obtained, I know that my authorized representative or I have the right to receive a copy of this statement upon request.

I (check one) ❑ do ❑ do not request to be interviewed if such a consumer report is obtained.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

Signed in: _____ on _____
City, State Month, Day, Year

X_____ X_____
Signature of Proposed Insured Signature of Owner and/or Payor *(if different than Proposed Insured)*

Policyowner Information *(Required ONLY if owner is different than the proposed insured.)*

Full Name (First, Middle, Last) _____ Relationship to Proposed Insured _____
Street Address (Include street number and/or apt. #) _____
City, State _____ Zipcode _____ Telephone Number (with area code) _____

4. Payment Options *You can find your premium in the personalized chart enclosed in this package.*

Payment Frequency

❑ *Annual (One payment equal to 12 monthly payments.)*
❑ Monthly *(You must make your first payment by check or credit card. Then, recurring monthly payments must be made by electronic funds transfer from your checking account or by charges to your credit card. Complete Automatic Payment Plan Agreement in section 5 or the Credit Card Authorization enclosed.)*

First Payment

❑ Check enclosed *(Make check payable to Amica Life.)*

Amount $_____ Check # _____

❑ Credit Card *(Complete the Credit Card Authorization on the enclosed form.)*

5. Automatic Payment Plan Agreement

Complete only if you chose the monthly payment frequency in section 4 for which premiums will be paid by electronic funds transfer from your checking account. Do NOT complete if paying premiums by check or credit card.

I request and authorize Amica Life Insurance Company to make monthly withdrawals against the account specified on the attached check or any account named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premiums under this plan.

Bank Name _____ Bank Account Number _____

Amount Authorized _____

Important: Attach voided personal check *(It is used to verify bank account and routing numbers only.)*

Name(s) on Account (Please Print) _____

Signature(s) _____ Date _____

Return in enclosed postage-paid envelope with your first payment
If you are paying your premium(s) by credit card, you must complete the Credit Card Authorization enclosed.

Use this space to provide details if you answered "YES" to any of the medical/health questions in this application.
Please print.