Please print in ink. Initial any changes.

Individual Life Insurance Application

1. Proposed Insured Information

Gender:

Full Legal Name (First, Middle, Last): _____ ☐ M ☐ F

Maiden Name (if applicable): _____ Date of Birth: _____

Social Security Number: _____

Telephone Number: Preferred Number: ☐ Home ☐ Work ☐ Mobile

Home: _____ Work: _____ Mobile: _____

E-mail Address: _____

Resident Address: *(Not a PO Box. Include street address and number, and/or apt. #)*

Street Address: _____ Apt. or Unit #: _____

City: _____ State: _____ Zip Code: _____

2. Personal Physician

☐ *Check here if you do NOT have a primary health care provider or personal physician, and proceed to Section 3.*

Primary Health Care Provider/Personal Physician : _____

Telephone Number: _____

Address: *(Not a PO Box. Include street address and number, and/or apt. #)*

Street Address: _____ Apt. or Unit #: _____

City: _____ State: _____ Zip Code: _____

Date Last Consulted: _____

Reason for Visit: _____

_____

Results, findings, or treatment (Provide details, including the name and dosage of any prescriptions):

_____

_____

Has this been fully resolved? _____

**Where more space is needed, use Section 4 on page 3.*

Continued on next page.

3. Medical History

Please provide complete details for any "yes" answers.*

A. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for a disease or disorder of:

1. Blood pressure? ☐ Yes ☐ No
2. Heart or blood vessels, including chest pains, heart attack or murmur, or stroke? ☐ Yes ☐ No
3. Cholesterol levels? ☐ Yes ☐ No
4. Skin or lymph glands, including any cancer, tumors, lymphoma or sarcoma? ☐ Yes ☐ No
5. Diabetes or condition of the thyroid, or other condition of the endocrine system? ☐ Yes ☐ No
6. Blood system, including anemia? ☐ Yes ☐ No
7. Intestinal bleeding, chronic diarrhea, recurrent indigestion, jaundice, chronic abdominal pain, celiac disease, or any stomach, gallbladder, intestinal, or liver disorder? ☐ Yes ☐ No
8. Psychiatric disorders, mental illness, depression or suicide attempt, or any other mental, emotional, or behavioral disorder? ☐ Yes ☐ No
9. Brain or nervous systems, including seizures, fainting, headaches, paralysis, memory or cognitive issues, or other neurological disorders? ☐ Yes ☐ No
10. Respiratory system, including asthma, sleep apnea, emphysema, COPD, chronic bronchitis, or any other disorder of the respiratory system? ☐ Yes ☐ No
11. Kidneys or genitourinary system, including stones, prostate, or other disorder of the reproductive system? ☐ Yes ☐ No
12. Bones, joints or muscles, including any deformity, chronic pain, fibromyalgia, ankylosing spondylitis, rheumatoid arthritis, or psoriatic arthritis? ☐ Yes ☐ No
13. Eyes, ears, nose or throat? ☐ Yes ☐ No
14. Alcohol or drug abuse or addiction in the last 10 years? ☐ Yes ☐ No
15. Immune system disorder, except those related to the Human Immunodeficiency Virus (AIDS virus)? ☐ Yes ☐ No

B. Have you ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

C. Within the last 10 years, have you used cocaine, marijuana, heroin, other recreational drugs, or any prescription drugs, except as prescribed by a physician? ☐ Yes ☐ No

D. Are you currently pregnant? ☐ Yes ☐ No

E. Are you scheduled for surgery, lab studies, or hospital care, or are you awaiting the results of any evaluation or test? ☐ Yes ☐ No

F. Within the last 2 years, have you had any medical treatment, consultation, or evaluation, other than as noted above? ☐ Yes ☐ No

G. Are you currently taking any medications? If yes, list medications*: ☐ Yes ☐ No

H. Within the last 5 years, have you had any blood, urine, X-ray, EKG, or other **lab test (NOT previously discussed)**, except any test related to the Human Immunodeficiency Virus or AIDS virus)? ☐ Yes ☐ No

4. Additional Information

Use the space below to provide any information that did not fit in the space provided on the application. Please include section number and question letter/number (*where applicable*).

When providing details for any "yes" answers in Section 3 (Medical History), be sure to include: *1) attending physician's name, address and telephone number, 2) dates/durations, 3) diagnosis/treatment/results, 4) current status, and 5) medications (if applicable).*

_____

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5. Acknowledgment and Signature *Please read and sign.*

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.

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_____
Signature of Proposed Insured

X_____
Signature of Custodial Parent/Guardian (if the Proposed Insured is a minor)