AAA Life Insurance Company

It's as easy as 1-2-3!

How to apply: Please complete in blue or black ink and print clearly. All sections must be complete to apply. Mail in the postage-free envelope. Your spouse may also apply with or without you, even if they are not a AAA member. **Questions? Call TOLL-FREE 1-800-624-1662.**

To get coverage as soon as possible, PLEASE COMPLETE AND MAIL BY AUGUST 12

Personal Code: XXX

FPO barcode

INDIVIDUAL DIRECT TERM LIFE INSURANCE APPLICATION

[999-999999999999999]
[XXXXXXXXXX 99999999999]

Step 1 Member Information

Name
First Middle Last

Home Address
City State Zip Code

Phone Number ( )

Email Address

Beneficiary Name

Beneficiary Relationship

Member Coverage Amount Desired

❑ $50,000 ❑ $100,000 ❑ $200,000 ❑ $300,000

In the last 12 months, have you used nicotine in any form? ❑ Yes ❑ No

Gender ❑ Male ❑ Female

Birth Date / / (Must be age 18-74 to apply.)

Height ft. in. Weight lbs.

Are you a U.S. citizen? ❑ Yes ❑ No
If No, do you have an alien registration card (green card)? ❑ Yes ❑ No

Spouse* Information — Only if Applying

Name
First Middle Last

Home Address
City State Zip Code

Phone Number ( )

Email Address

Beneficiary Name

Beneficiary Relationship

Spouse Coverage Amount Desired

❑ $50,000 ❑ $100,000 ❑ $200,000 ❑ $300,000

In the last 12 months, have you used nicotine in any form? ❑ Yes ❑ No

Gender ❑ Male ❑ Female

Birth Date / / (Must be age 18-74 to apply.)

Height ft. in. Weight lbs.

Are you a AAA member or spouse of a member? ❑ Yes ❑ No

Are you a U.S. citizen? ❑ Yes ❑ No
If No, do you have an alien registration card (green card)? ❑ Yes ❑ No

**Spouse includes Registered Domestic Partner, Civil Union Partner, or party to a domestic partnership between two adults, as recognized by state law.*

Step 2 Provide Payment Method — Choose ONLY One Option

1. ❑ Deduct payment from my checking account each month. *(Enclose a check marked VOID or provide your account/routing information below.)*
   Account Number: Routing Number:
2. ❑ Charge payment to my credit/debit card each month. (VISA, MasterCard, Discover, and AmEx are accepted.)
   Card Number: Expiration Date: /

Complete if Choosing Payment Option 1 or 2

Print name as it appears on account or card:

Date for deduction from your checking account or credit/debit card (Choose day 1-28).
If no date is indicated, your payment will be deducted immediately upon approval.

3. ❑ Send me a bill each month. $3 fee per month applies. (You may not select a date to receive a bill. Your bill will be sent upon approval.)

Step 3 Statement of Health — Each applicant must complete all questions. A YES answer will not automatically disqualify you for coverage.

1. In the past 12 months, have you had diagnostic testing (excluding Human Immunodeficiency Virus (AIDS virus)) performed or recommended by a doctor for an undiagnosed condition?
   Member: ❑ Yes ❑ No **Spouse:** ❑ Yes ❑ No
2. In the past three years, have you been treated OR diagnosed by a doctor as having heart trouble, cancer, stroke, lung disease, liver disease, kidney disease, AIDS, lupus, ALS, or dementia?
   Member: ❑ Yes ❑ No **Spouse:** ❑ Yes ❑ No
3. In the past three years, have you been confined to a nursing home or special treatment facility OR convicted of a felony or driving under the influence?
   Member: ❑ Yes ❑ No **Spouse:** ❑ Yes ❑ No

Step 4 Other Insurance

Is the insurance applied for intended to replace, discontinue, or change any existing insurance or annuity?
Member: ❑ Yes ❑ No **Spouse:** ❑ Yes ❑ No

Step 5 Read, Sign, and Date

All answers in this application are, to the best of my knowledge and belief, true. I understand the answers will be used to determine if coverage will be issued, and the application will be part of the Policy of Insurance (Policy). • In accordance with its incontestability provision, if I misstate any of the information on this application, in the absence of fraud, the Policy may be voidable for 24 months from the Effective Date by AAA Life Insurance Company (the Company). • I authorize the Company to use the payment method I indicated on this application. This authorization will remain in effect until I notify the Company, in writing, to cancel it. • Coverage will take effect on the Effective Date shown on the Policy, provided the first premium has been paid and there has been no change in my health since the date of the application. If my health changes prior to the Effective Date of the Policy, I must promptly inform the Company in writing. • I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical-related facility, consumer reporting agency, insurance company, or other organization that has any records or knowledge of my medical or prescription history, credit attributes, public records, driving record, or social security number, to give any such information to the Company, its reinsurer(s) or any entity retained by the Company to collect and transmit such information. • The Company will not use or disclose medical information for any purpose other than stated above except as may be required or permitted by law. Such medical information may be subject to redisclosure and may no longer be protected by federal privacy regulations, however, they may be protected by state regulations. • This authorization shall be valid for 24 months from the date signed. The time limit complies with the time limit, if any, permitted by applicable law in the state where the Policy is delivered or issued for delivery. I understand I or my representative have a right to a copy of this authorization. • I may revoke this authorization at any time by writing to the Company; and if I do, the Company may decline my application. • **Fraud Warning: See other side.**

[X] Member Signature (Required if applying) Today's Date

[X] Spouse Signature (Required if applying) Today's Date

Fraud Warning

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.

Option to Designate Secondary Addressee

AAA Life Insurance Company provides you with the option to designate someone, in addition to yourself, to receive notice when your life insurance premium is outstanding. This is an ideal way to ensure that the valuable coverage you have remains in effect. This is optional and not required as part of the application process. If you wish to designate a secondary addressee, please complete the following:

Secondary Addressee of Member (if applying): Name_____

Street Address_____City_____

State_____Zip_____Phone Number_____

Secondary Addressee of Spouse (if applying): Name_____

Street Address_____City_____

State_____Zip_____Phone Number_____