American Memorial (assurant) application
Min face: $3000
Max face: $25000
Age range 0-85

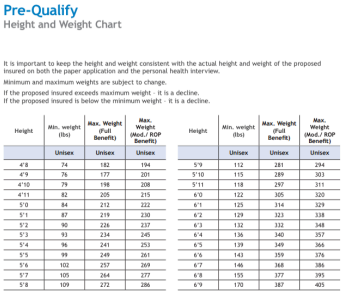
Filling Out Application
Fill out red highlighted boxes with your signature/agent number/etc. Make copy after filling out red highlighted boxes.
Always make a duplicate copy of file ***BEFORE*** filling out application with client info
Retitle file with clients first and last name
Fill out yellow highlighted boxes with client info
We will use this company for level and modified benefit
If all health questions in part A & B are no then insured is eligible for level coverage.
If any question in part B is yes then insured is eligible for modified coverage (return of premium plus 10% interest first 2 yrs).
Questions in section 5 and the agents statement answers for replacement need to match.
If "yes" to existing insurance question, a replacement form needs to be filled out **even if it no replacement is occurring**
When filling out replacement page, you only need to fill out replaced insurance company **IF you are replacing**

How to Quote with Cardinal Quoting App (make sure it says "assurant")

Level
Underwriting Type: Full
Product Type: Level

Modified
Underwriting Type: Full
Product Type: Return of Premium

AMERICAN MEMORIAL LIFE IN...
Assurant
Premium: $46.53/mo*
Face Value: $10,000.00
Annual Fee: $30.00



Pre-Qualify
Height and Weight Chart

It is important to keep the height and weight consistent with the actual height and weight of the proposed insured on both the paper application and the personal health interview.
Minimum and maximum weights are subject to change.
If the proposed insured exceeds maximum weight - It is a decline.
If the proposed insured is below the minimum weight - It is a decline.

Height	Min. weight (lbs)	Max. Weight (Full Benefit)	Max. Weight (Mod./ ROP Benefit)
	Unisex	Unisex	Unisex
4'8	74	182	194
4'9	76	177	201
4'10	79	198	208
4'11	82	205	215
5'0	84	212	222
5'1	87	219	230
5'2	90	226	237
5'3	93	234	245
5'4	96	241	253
5'5	99	249	261
5'6	102	257	269
5'7	105	264	277
5'8	109	272	286

Height	Min. weight (lbs)	Max. Weight (Full Benefit)	Max. Weight (Mod./ ROP Benefit)
	Unisex	Unisex	Unisex
5'9	112	281	294
5'10	115	289	303
5'11	118	297	311
6'0	122	305	320
6'1	125	314	329
6'2	129	323	338
6'3	132	332	348
6'4	136	340	357
6'5	139	349	366
6'6	143	359	376
6'7	146	368	386
6'8	155	377	395
6'9	170	387	405

AML interview process
-Phone interview number 888-842-2266
-interviewer will ask for agent number, and form number at the bottom of app.
-IMPORTANT!! Interviewer will ask you if client has seen the fraud statement at top of app, inform client of fraud statement!!!
-IMPORTANT!! Interviewer will ask you if you have completed the application with client, say yes!!!!!
-IMPORTANT!! Interviewer will ask your client every question on the app word for word.
-IMPORTANT!! Interviewer will asked detailed questions about medications, make sure the client is prepped for medication questions and knows what to say when asked why they are taking each medication.
*note this company is best option for heart issues within 12 months and are eligible for modified.
*Question 2.A if client has had COPD for more than 36 months and no nebulizer, no oxygen, and no COPD symptoms (bronchitis/emphysema issues in last 36 month) client can get level 1st day coverage. Explain this to interviewer but mark no on the app to this question.

How to Submit App
Delete instruction page before submitting
Email completed application to fmoefax@assurant.com
Fax: 605-719-0610
Can also use the CSB Submission link: https://www.cognitoforms.com/Access15/cardinalseniorbenefitsapplicationsubmissionform

After Submitting
Moving file from "Applications" folder to "Client" folder
Log client into Senior Agent Tools

Application for Life Insurance

American Memorial Life Insurance Company
P.O. Box 2730 • Rapid City, SD 57709

Proposed Insured: _____

HOME OFFICE USE ONLY # _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Proposed Insured

_____
First Middle Initial Last

Address: _____
Street

_____
City State Zip

Telephone Number: (Home) _____ (Cell) _____

Date of Birth: _____ Current Age: _____ State of Birth: _____

SSN#: _____ ❑ Male ❑ Female Height: _____ Weight: _____

Drivers License Number: _____ State: _____

U.S. citizen? ❑ Yes ❑ No If not, do you have an immigration card? ❑ Yes ❑ No Card #: _____

Have you applied for life insurance with any other insurance company in the last two years? ❑ Yes ❑ No

2. Owner Information (If different from Proposed Insured)

_____
First Middle Initial Last

Address: _____
Street

_____
City State Zip

Telephone Number: (Home) _____ (Cell) _____

SSN#: _____ Relationship to Proposed Insured: _____

3. Primary Beneficiary

Full Name: _____

Relationship to Proposed Insured: _____

4. Contingent Beneficiary

Full Name: _____

Relationship to Proposed Insured: _____

5. Policy Information:

Face Amount: $ _____ Premium: $ _____ Effective Date: _____

Plan: ❑ Level Benefit Whole Life ❑ Modified Benefit Whole Life

Has the Proposed Insured used nicotine based products in the past 12 months? ❑ Yes ❑ No

Replacement: Do you have any existing life insurance policies or annuity contracts? ❑ Yes ❑ No

If yes, give name and address of existing insurer & policy number, if available: _____

Policy Mailing: ❑ Agent ❑ Owner

Proposed Insured: _____

6. Health Questions

Part A Questions: If Proposed Insured answers "YES" to any question in Part A or does not meet the height and weight requirements, he/she is not eligible for coverage. If all questions are answered "NO" in Part A, proceed to Part B and answer questions. If all questions are answered "NO" in Parts A and B and the Proposed Insured meets the height and weight requirements, he/she will be considered for the Level Benefit Whole Life Plan.

	YES	NO	
1.	❑	❑	Do you have any impairment, whether physical or mental, for which you need or receive assistance or supervision in performing normal activities of daily living such as bathing, toileting, eating, dressing, taking medications, or moving without any type of physical assistance, or are you currently hospitalized, confined to a bed or nursing facility, receiving hospice care, or do you require oxygen to assist in breathing?

2. Have you ever:

a.	❑	❑	Had, or been medically advised to have, an internal organ transplant, or been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?
b.	❑	❑	Taken insulin by injection or other method prior to age 45 or been medically diagnosed, taken medication for, been treated or been advised to have treatment for chronic kidney disease, dialysis, kidney or liver failure, cirrhosis, liver disease, congestive heart failure (CHF), cardiomyopathy, organic brain syndrome, Alzheimer's, dementia, or Lou Gehrig's disease (ALS)?
c.	❑	❑	Been diagnosed by a medical professional as having, or been medically treated or been advised to have treatment for acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the human immunodeficiency virus (HIV)?
d.	❑	❑	Had more than one occurrence of any cancer or any metastasis in your lifetime (excluding Basal or Squamous cell skin cancer), or are you currently being treated or been advised to have treatment for cancer or recurrence of cancer or had an amputation caused by cancer?
e.	❑	❑	Been diagnosed with neuromuscular or brain disease (including cerebral palsy, muscular dystrophy, multiple sclerosis, cystic fibrosis), systemic lupus (SLE) or paralysis of two or more extremities?

3. Within the past 24 months have you been medically diagnosed as having, been treated or been advised to have treatment for, taken medication for or been hospitalized for:

a.	❑	❑	Internal cancer, leukemia, lymphoma, melanoma, Hodgkin's disease or Parkinson's disease?
b.	❑	❑	Insulin shock, diabetic coma, or diabetic complications (including neuropathy, retinopathy, or amputation)?

Part B Questions: If the Proposed Insured answers "YES" to any question in Part B, he/she will be considered for the Modified Benefit Whole Life Plan only.

1.	❑	❑	Within the past 24 months have you been medically diagnosed as having, been treated or been advised to have treatment for, or been hospitalized for stroke, transient ischemic attack (TIA), angina, coronary artery disease, heart attack, heart or vascular surgery (including coronary artery bypass, pacemaker, heart valve replacement, abdominal aortic aneurysm, angioplasty, stent placement) or any procedure to improve circulation to the legs, heart or brain?

2. Within the past 36 months have you:

a.	❑	❑	Been medically diagnosed as having, been treated or been advised to have treatment for, or been hospitalized for schizophrenia, bipolar disorder, or alcohol or drug abuse, chronic obstructive pulmonary or lung disease (COPD), emphysema, or chronic bronchitis?
b.	❑	❑	Been confined three or more times to a hospital, nursing facility, convalescent care facility or mental facility?
c.	❑	❑	Been declined or postponed for life or health insurance or attempted suicide?

Current Physician and Address: _____

_____

Are you taking any medication for any impairments listed in the above Health Questions? ❑ Yes ❑ No

Proposed Insured: _____

Conditions Relating to the Application: I have read the questions and answers in all parts of this Application. I agree that they are complete and true to the best of my knowledge and belief. I agree that this Application and any supplement to the Application, if required, shall be attached to and form a part of any policy issued.

Acknowledgement: I have read and understand the Conditions Relating to the Application, the Medical Authorization information, and this Acknowledgement. I acknowledge receipt and review of the Notice to the Applicant and (where required by law) a Buyer's Guide and any other required preliminary cost information.

I understand and agree that no insurance agent has the authority to waive an answer to any question in the Application, pass on insurability, make or alter any contract, or waive any of the Company's rights or requirements. I understand that I (or my authorized representative) may receive a copy of this Application. I understand and agree that any policy applied for shall not take effect (except as provided in the Conditional Premium Receipt bearing the same name as this Application) unless and until

(a) the Company has received and approved this Application for insurance;
(b) the Company has issued a policy based upon this Application;
(c) the policy has been issued and delivered and the first full premium has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in this Application;
(d) the Company has drafted the designated account for the first premium; and
(e) the person to be insured remains alive at the time the premium payment is honored.

SIGNATURES:

Proposed Insured Signature _____ Date _____

Owner Signature _____ Date _____
(If different from Proposed Insured)

Witness or Licensed Agent Signature _____ Date _____

Signed at: _____
City State

Agent's Statement - I certify that the owner, proposed insured, or any person or entity is not being paid cash or promised services as an inducement to enter into this insurance transaction and that this insurance transaction will not be sold or assigned for any type of viatical settlement, senior settlement, life settlement, or any other secondary market.

Did you see the Proposed Insured at the time this application was completed? ❑ Yes ❑ No

Replacement: Does the proposed insured have any existing life insurance policies or annuity contracts? ❑ Yes ❑ No

If a replacement is involved, I certify that I only used company approved sales materials.

_____ _____
Primary Writing Agent Signature State License No. Secondary Writing Agent Signature State License No.

_____ _____
Print Primary Writing Agent Name Agent # % Split Print Secondary Writing Agent Name Agent # % Split

_____
Primary Writing Agent Telephone Number

Proposed Insured: _____

7. Payment Options

Premium Amount $ _____

• Pre-Authorized Check Automatic Withdrawal (PAC) is the automatic withdrawal from your checking or savings account.

❑ **Monthly:**

• PAC is ***only*** available with a premium payment frequency of monthly.
• Future payment by check is **not** available with a premium payment frequency of monthly.
• All future payments must be PAC regardless of first payment method.

First Payment:

❑ Check* (Payable to AML)

❑ PAC First Pre-Authorized Withdrawal Date _____
Month / Day

The first pre-authorized withdrawal must be within 30 calendar days of the date you sign this application. Withdrawal dates are available from the 1st - 28th of the month only. *All future pre-authorized withdrawal dates will coincide with the date requested for the first pre-authorized withdrawal.*

Future PAC Payments from ❑ Checking ❑ Savings

Name of Financial Institution _____

Routing Number _____ Account Number _____

Account Holder's Printed Name _____

Account Holder's Signature _____

If first payment method is check, the PAC withdrawal date will coincide each month on or about the effective date of the policy unless another day of the month is specified _____.
Day

❑ **Quarterly,** ❑ **Semi-Annual or** ❑ **Annual:**

• Future payment by check is available with a premium payment frequency of quarterly, semi-annual or annual.

First Payment:

❑ Check* (Payable to AML)

Future Payments:

❑ Check* (Payable to AML)

*When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you may not receive your check back from your financial institution. For inquiries please call 1-800-621-7162.

Medical Authorization
For use with Life Insurance Applications.
This Authorization complies with the HIPAA Privacy Rule.

Proposed Insured: _____

_____ _____
Name of primary proposed insured/patient Date of birth

_____ _____
Name of unemancipated minors Date of birth

I authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, pharmacy benefit manager, pharmacy, MIB, Inc., laboratory, medical facility, insurance company, insurance support organization (or any of its members or affiliates), the Veteran's Administration, my employer, consumer reporting agency, or any other health care provider that has provided payment, treatment or services to me or on my behalf or on the behalf of my unemancipated minor children (collectively, "My Providers") to disclose the entire medical record and any other protected health information concerning me or my above named unemancipated minor children to American Memorial Life Insurance Company ("the Company") or its reinsurers, their agents, employees, and representatives. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. 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. I acknowledge receipt of the MIB, Inc. Pre-Notice and Fair Credit Reporting Act Pre-Notice.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to 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 shall remain in force for 24 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 obtain a copy of this authorization and to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at Attention: Privacy Task Force, P.O. Box 2730, Rapid City, SD 57709. 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 redisclosure 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 or that of my unemancipated minor children, 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 (or my authorized representative) have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Personal Representative Date

_____ _____
Signature of Primary Proposed Insured/Personal Representative Date

If signed by an individual's Personal Representative, describe authority to sign on behalf of individual:
{ } Parent { } Power of Attorney { } Legal Guardian { } Other _____

ASSURANT Solutions®

American Memorial
Life Insurance Company
440 Mt. Rushmore Road
Rapid City, SD 57701

Important Notice: Replacement of Life Insurance or Annuities

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured or Annuitant	Replaced (R) or Financing (F)
1			
2			
3			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____ _____

Applicant's Signature | Applicant's Printed Name | Date

_____ _____ _____

Producer's Signature | Producer's Printed Name | Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)