Americo Financial Life and Annuity Insurance Company

Home Office: Dallas, Texas • Administrative Office: P.O. Box 410288, Kansas City, MO 64141-0288

Supplemental Application for Disability Income Rider

1. Proposed Insured (Print full name)	
2. Additional Proposed Insured (Print full name)	

Complete this Section for All Applicants

	Proposed Insured	Additional Proposed Insured
3. Amount of Monthly Disability Income Desired	$_____	$_____
4. Disability Income Period Desired	❒ 1Year ❒ 2Year	❒1Year ❒ 2Year
5. Is the Proposed Insured/Additional Proposed Insured currently employed full time (30 hours per week) and able to perform all of his or her regular duties? (If "No", give details in Remarks section)	❒ Yes ❒ No	❒ Yes ❒ No
6. How long employed with current employer? Annual earned income, as reported on prior year's tax return, after expenses (if self-employed or business owner) but before taxes:	____Yrs. ____Mos. $_____	___Yrs. ___Mos. $_____
7. Occupation (Give title and duties):		
(a) Percentage of time you perform heavy manual labor	_____%	_____%
(b) Percentage of time you perform light manual labor	_____%	_____%
(c) Percentage of time you perform no manual labor	_____%	_____%
(d) Percentage of time you spend performing sales duties	_____%	_____%
(e) Percentage of time you spend working inside	_____%	_____%
8. Name and Address of Employer:		
9. Phone Number:	Home ( ) Work ( )	Home ( ) Work ( )
10. Within the past three (3) years, has the Proposed Insured/Additional Proposed Insured ever been convicted of driving while under the influence?	❒ Yes ❒ No	❒ Yes ❒ No
11. Is the Proposed Insured/Additional Proposed Insured eligible to receive or does the Proposed Insured/Additional Proposed Insured have in force any other disability income insurance to include: Group LTD, Individual Disability, State Disability Insurance, STD or Salary Continuation? If "Yes", please complete the table below.	❒ Yes ❒ No	❒ Yes ❒ No

Specify Name of Proposed Insured/Additional Proposed Insured	Company or Source	Type	Year Issued	Benefit Amount	Benefit Period

	Proposed Insured	Additional Proposed Insured
12. Has Any Proposed Insured ever filed for or received disability or Worker's Compensation benefits?	❒ Yes ❒ No	❒ Yes ❒ No
13. Is the Proposed Insured/Additional Proposed Insured now pregnant? (If "Yes", how many months?)	❒ Yes ❒ No (_____)	❒ Yes ❒ No (_____)

	Proposed Insured	Additional Proposed Insured
14. Within the past ten (10) years, has the Proposed Insured/Additional Proposed Insured ever been treated for:		
(a) Paralysis, deformity, loss of limb or any disorder of the eyes, ears, nose or throat?	❒ Yes ❒ No	❒ Yes ❒ No
(b) Epilepsy, convulsions, anxiety, depression or any disorder of the thyroid, pancreas or other glands?	❒ Yes ❒ No	❒ Yes ❒ No
(c) Varicose veins, phlebitis, anemia, leukemia, bleeding tendency or any other disorder of the blood or blood vessels?	❒ Yes ❒ No	❒ Yes ❒ No
(d) Ulcer, hernia, hemorrhoid, colitis or any disorder of the stomach, intestines, rectum or gallbladder?	❒ Yes ❒ No	❒ Yes ❒ No
(e) Sexually transmitted disease or any disorder of the bladder, prostate, uterus, breast or Reproductive organs?	❒ Yes ❒ No	❒ Yes ❒ No
(f) Arthritis, gout or any disorder of the muscles or bones including the spine, back and joints?	❒ Yes ❒ No	❒ Yes ❒ No
15. Within the past three (3) years, has the Proposed Insured/Additional Proposed Insured ever had his or her driver's license suspended or revoked or received 3 or more moving violations? (If "Yes", give details and driver's license number and State in Remarks section.)	❒ Yes ❒ No	❒ Yes ❒ No
16. Has the Proposed Insured/Additional Proposed Insured consulted a physician or been hospitalized for any reason in the past five (5) years?	❒ Yes ❒ No	❒ Yes ❒ No
17. Has the Proposed Insured/Additional Proposed Insured ever been diagnosed as having or been treated by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any immune deficiency related disorder or tested positive for antibodies to the HIV virus?	❒ Yes ❒ No	❒ Yes ❒ No

Remarks

Proposed Insured:

Additional Proposed Insured:

I/we represent to the Company that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief and that the Company can rely on these statements. I/we further agree that this supplemental application shall be made a part of the policy to which it applies.

Signed at _____ on _____
(City and State) (Month, Day, Year)

Proposed Insured	Owner (if other than Proposed Insured)	Witness (Agent)
Additional Proposed Insured	Owner (if other than Additional Proposed Insured)	Witness (Agent)