AMERICAN EQUITY INVESTMENT LIFE INSURANCE COMPANY
HOME OFFICE:
PO BOX 9304
Des Moines, IA 50306-9304
888-221-1234 | Fax 515-221-9450
www.american-equity.com

LIFE DIVISION:
20 Cropwell Drive, Ste. 100
Pell City, AL 35128
877-508-9888

INDIVIDUAL LIFE APPLICATION

1. PROPOSED INSURED/OWNER INFORMATION

Name (first, middle, last):		Married ❑ Yes ❑ No
SSN:	Date of Birth (mm/dd/yyyy):	❑ Male ❑ Female
Permanent physical address (Street address required, PO Box Optional): City, State, Zip Code:		
Telephone Number:	E-mail (Optional):	

OWNER INFORMATION (if other than the Proposed Insured) Leave blank if Proposed Insured is the same person

Name (first, middle, last):		Relationship to Proposed Insured:
SSN:	Date of Birth (mm/dd/yyyy):	❑ Male ❑ Female
Permanent physical address (Street address required, PO Box Optional): City, State, Zip Code:		

2. BENEFICIARY DESIGNATION (ONE Primary Beneficiary is required. % must total 100%, per beneficiary class)

Primary	Share %	Relationship:	
Name (first, middle, last):		SSN/TIN:	
		Birthdate:	Phone #:
Address, City, State, Zip:			
❑ Primary ❑ Contingent	Share %	Relationship:	
Name (first, middle, last):		SSN/TIN:	
		Birthdate:	Phone #:
Address, City, State, Zip:			

_____
Owner's Spouse's Signature*

*Required in ID, LA, NM, NV, TX, WA and WI. Spouse consents to beneficiary designations. Not required if Spouse is Sole Primary Beneficiary.

3. PRODUCT INFORMATION (Products not available in all states)

Name:

4. METHOD OF PURCHASE

	Self	Dependent Children
Face Amount:	$	$
Planned Premium Amount* $		❑ Check ❑ EFT (Complete Form #4062)

Premium Mode ➡ ❑ Monthly ❑ Bi-Weekly ❑ Other _____

If Available, I request the automatic premium loan provision on the above policy(ies). ❑ Yes ❑ No

*Made payable to American Equity Investment Life Insurance Company

5. ADDITIONAL INFORMATION

Are you the owner, insured and/or annuitant of any existing life insurance with this or any other company? If "Yes" complete replacement form(s).	❑ Yes ❑ No
Will this life policy replace or change any life insurance or annuity policy? If "Yes" complete replacement form(s).	❑ Yes ❑ No
Has any Owner, Annuitant or beneficiary entered into an agreement to sell or assign this life policy? If "Yes" please attach a written explanation.	❑ Yes ❑ No
Has any Owner, Annuitant, or beneficiary ever sold, transferred or assigned a life insurance or annuity policy to a third party? If "Yes" please attach a written explanation.	❑ Yes ❑ No

PROPOSED INSURED HEALTH INFORMATION

1. Have you ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a member of the medical profession for: Alzheimer's disease, dementia, memory loss, muscular dystrophy, ALS (Lou Gerhig's disease) congestive heart failure, cardiomyopathy, chronic kidney disease, kidney failure, received kidney dialysis, cirrhosis of the liver, liver failure, emphysema, chronic obstructive pulmonary disease (COPD), metastatic cancer, internal cancer, malignant melanoma, AIDS, ARC, or HIV, or complications of diabetes.	❑ Yes ❑ No
2. Within the past 3 years have you been advised to have tests, surgery or hospitalization (except for those related to HIV or AIDS), which have not been completed, or waiting for a medical diagnosis or results of medical tests or procedures which have not been received?	❑ Yes ❑ No
3. Within the past 3 years have you used narcotics (other than as prescribed by a member of the medical profession), amphetamines, hallucinogens, heroin, or cocaine?	❑ Yes ❑ No
4. In the past 3 years, have you received a diagnosis, been treated, received medical treatment or counseling of been prescribed medication by a member of the medical profession for drug or alcohol abuse/dependency or addiction?	❑ Yes ❑ No
5. Within the past 3 years have you been diagnosed, treated or tested positive, or given medical advice by a member of the medical profession for: bipolar disorder, schizophrenia, manic or clinical depression, psychosis, mental incapacity, post-traumatic stress disorder, suicidal thoughts, brain tumor, Huntington's disease, heart disease, aneurysm, stroke or TIA?	❑ Yes ❑ No
6. Have you ever been refused, postponed or rated up by an insurance company?	❑ Yes ❑ No

IF THE ANSWER FOR ANY POTENTIAL INSURED IS YES TO ANY OF THE ABOVE QUESTIONS, INDICATE BELOW, WHICH INSURED, THE NATURE, DURATION AND SEVERITY OF THE ILLNESS OR INJURY. GIVE DATES, PRESCRIBED AND NON-PRESCRIBED MEDICATION, PROVIDE THE NAME AND ADDRESS OF THE PHYSICIAN. THE DATE AND NAME OF THE INSURANCE COMPANY AND REASON FOR REFUSAL, POSTPONEMENT OR RATING.

_____

_____

_____

_____

_____

Each person who signs below acknowledges that he/she has read and understands this Application and has read and understands the Information Practices outlined on the back of this form.

7. NOTICE

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.

8. STATEMENTS AND SIGNATURES

PROPOSED INSURED/OWNER STATEMENT

I hereby authorize any physician, medical professional, hospital, clinic or medical care facility; pharmacy benefit manager, prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the MIB, Inc. (MIB), to provide the Company and its legal representatives or affiliated insurers, all information , including protected health information, they have pertaining to: medical consultations; treatments; hospitalizations for physical and/or mental conditions, use of drugs or alcohol; drug prescriptions; or any other information for me. Other information could include such items as: other insurance information; personal finances; habits; hazardous avocations; motor vehicle records; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine my eligibility for insurance. I authorize that any personal or protected health information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent. Information released in response to this authorization may be re-disclosed to other parties and may no longer be protected by federal rules governing privacy and confidentiality.

I understand that this consent may be revoked at any time, except to the extent information has been released in reliance upon this authorization prior to receiving notice of my revocation. To revoke this consent, send written request to the Company, American Equity Investment Life Insurance Company, PO Box 9304, West Des Moines, IA 50266.

This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I understand that I have a right to a copy of this form. I authorize the Company to obtain an investigative report on me. I understand that I may be interviewed for the report and receive, upon written request, a copy of such report.By signing below, the Proposed Insured and Owner acknowledges the statements mentioned above and agrees to the following:

1. **All statements and answers to questions in this application are true to the best of my knowledge and belief.**
2. **I understand that I may return my policy within the free-look period if I am dissatisfied for any reason.**
3. **I believe this product is suitable for my goals.**
4. **I understand that a sales agent does not have the company's authorization to accept risk, pass insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.**

_____ _____

(Owner's Signature) (Proposed Insured's Signature, if other than the owner)

Signed at _____

(City) (State and Zip) (Date)

9. AGENT OF RECORD

To the best of my knowledge the applicant has existing life insurance policy or annuity contract where s/he is the owner, annuitant or insured. ❑ Yes ❑ No If "Yes", complete replacement form(s).

OWNER VERIFICATION

U.S. Citizen? ❑ Yes ❑ No	Type of Government Issued ID:	ID Number:	Issued by:

I have personally reviewed the government issued identification for the Owner and confirmed the personal identification information provided by the applicant as noted above.

By signing this form, I certify that: 1) replacement questions were answered; 2) a copy of any sales material shown to the applicant(s) was left with the applicant(s); 3) I used only insurer-approved sales material; 4) I have not made any statements that differ from the sales material; 5) I have truly and accurately recorded on the application the information provided by the applicant(s); and 6) I made no promises about the future values of any contract elements that are not guaranteed. (This includes any expected future gains that may apply to this contract.)

_____ _____

Primary Licensed Agent (Print Name) Primary Licensed Agent Signature

Agent Number:	Telephone Number:
Relationship to Owner:	

10. DETACH AND LEAVE WITH APPLICANT

INFORMATION PRACTICES

FAIR CREDIT REPORTING ACT NOTICE

I (We) understand, as part of the normal procedure of processing an application, The Company may obtainan investigative consumer report concerning such information as character, general reputation, personal characteristics such as health, finances, job, through personal interviews with friends, neighbors, and associates. We may request further information on the nature and scope of any such report, by requesting it in writing from The Company.

APPLICANT'S PRE-NOTICE

The Company treats information regarding your insurability as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuaracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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