



Founded 1954

**Application  
PREMIER SERIES Deferred Annuity**

AMERICAN SAVINGS LIFE INSURANCE COMPANY  
480.835.5000 | 800.880.2112 | fax:480.835.5355  
935 E Main Street, Mesa, Arizona 85203

**1. OWNER:** (Must be between ages 18 and 80)  Male  Female  
 All Policyholder correspondence will be sent to this address)  
 NAME: \_\_\_\_\_  
Last Name First Middle  
 ADDRESS: \_\_\_\_\_  
Street City State Zip Code  
 SS# or Tax ID#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE#: \_\_\_\_\_  
Month Day Year  
 TRUST INCEPTION DATE (include Trust Declaration Page): \_\_\_\_\_

**2. JOINT OWNER(S):** (Must be between ages 18 and 80)  Male  Female  
 if more than one joint owner, attach a separate sheet in same format  
 NAME: \_\_\_\_\_  
Last Name First Middle  
 ADDRESS: \_\_\_\_\_  
Street City State Zip Code  
 SS# or Tax ID#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE#: \_\_\_\_\_  
Month Day Year

**3. ANNUITANT:** (if different than owner – must be between ages 18 and 80)  Male  Female  
 NAME: \_\_\_\_\_  
Last Name First Middle Initial Relation to Owner  
 ADDRESS: \_\_\_\_\_  
Street City State Zip Code  
 SS# or Tax ID#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE#: \_\_\_\_\_  
Month Day Year

**4. BENEFICIARY(IES):** (Joint Owner(s) will be the Primary Beneficiary(ies) unless otherwise indicated.)  
 If you do not want the Joint Owner to be the Primary Beneficiary, check here and name Beneficiary below:   
 NAME: \_\_\_\_\_  
Last Name First Middle Initial  
 ADDRESS: \_\_\_\_\_  
Street City State Zip Code  
 SS# or Tax ID#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE#: \_\_\_\_\_  
Month Day Year

**5. TYPE OF ANNUITY:**  Premier Series 1300-3  
 Premier Series 1300-5 Total Initial Premium: \$ \_\_\_\_\_ (\$5,000 to \$350,000)  
 Premier Series 1300-7

**6. THIS ANNUITY IS BEING APPLIED FOR AS:**  Non-Qualified  1035 Exchange  Other

**7. YOUR CANCELLATION RIGHTS**

**IF FOR ANY REASON** THE CONTRACT HOLDER IS NOT SATISFIED WITH THE ANNUITY CONTRACT, THE CONTRACT HOLDER MAY RETURN THE ANNUITY CONTRACT **WITHIN THIRTY DAYS** AFTER THE CONTRACT IS DELIVERED **AND RECEIVE A REFUND OF ALL MONIES PAID.**

**8. YOUR RIGHT TO MORE INFORMATION**

Upon written request, the Company will provide within a reasonable time reasonable factual information regarding the benefits and provisions of this annuity contract to the contract holder.

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**9. REPLACEMENT**

Do you have existing life insurance or annuity contracts?  Yes  No  
If yes, will this policy replace existing life insurance or annuities?  Yes  No

If you intend on replacing existing life insurance or annuities, please list each existing insurance policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy 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	REPLACED (R) OR FINANCING (F)
1. _____	_____	_____	_____
2. _____	_____	_____	_____

**10. APPLICANT'S ACKNOWLEDGMENT AND SIGNATURE**

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals information concerning any fact material thereto, commits a fraudulent insurance act which may subject such person to criminal and civil penalties.

SIGNATURE OF OWNER: **X** \_\_\_\_\_

APPLICATION SIGNED AT: \_\_\_\_\_ Date: \_\_\_\_\_  
City County State Month Day Year

SIGNATURE(S) OF JOINT OWNER(S) (IF APPLICABLE): **X** \_\_\_\_\_

SIGNATURE OF ANNUITANT (IF OTHER THAN OWNER): **X** \_\_\_\_\_

SIGNATURE OF SPOUSE: **X** \_\_\_\_\_  
*(Required In AZ, If beneficiary is other than Spouse)*

**11. AGENT'S QUESTION**

Does the Applicant have existing life insurance or annuity contracts?  Yes  No  
Do you have knowledge or reason to believe that the annuity applied for by this application will replace or change any insurance or annuity currently in force on the life of the proposed Annuitant?:  Yes  No

SIGNATURE OF AGENT: **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

AGENT'S NAME: \_\_\_\_\_

AGENT'S SOCIAL SECURITY # OR TAX ID #: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

AGENT'S ADDRESS: \_\_\_\_\_

AGENTS E-MAIL: \_\_\_\_\_