THE

AMERICAN SAVINGS
GRAND SLAM
LIFE INSURANCE PLAN

AMERICAN SAVINGS LIFE
INSURANCE COMPANY
935 E. MAIN STREET • MESA, AZ 85203
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(480) 835-5000 • 1-800-880-2112

APPLICATION FOR "ENDOWMENT AT AGE 95" LIFE INSURANCE

TO APPLY, SIMPLY:

(1) Complete both sides of this application (please *PRINT* legibly), then sign at the bottom of side 2;

(2) Enclose a check for the initial premium, for the mode you have selected;

(3) Mail the completed application and check to the address above.

NOTE: Questions #1-10 and #19 herein refer only to the Proposed Insured. All references to "you" or "your" refer to the Proposed Insured

1. **PROPOSED INSURED**: Name: _____ ☐ MALE ☐ FEMALE

2. Address: _____ City _____ State _____ Zip _____

3. Date of Birth: ___/___/___ Location: _____ U.S. Citizen? ☐ Yes ___ - ___ - _____
(month / day / year) (city & state) ☐ No (social security number)

4. Occupation: _____ Phone #: (___) ___ - _____

5. Personal Physician (Name, Address and Phone): _____

_____

6. Date and Reason for last visit with Physician: _____

7. Present Height: _____ ft. _____ in. Present Weight: _____ lbs.

9. Amount of insurance you have in force in all companies: Life: $_____ Accidental Death: $_____

10. Will you replace or change any existing life insurance policies or annuity contracts as a result of this application?
If yes, please write the name of the Company and the policy number: _____

11. **POLICY OWNER**: ☐ **Same as Insured** (If different, please complete this section.)
Name(s): _____ Relationship(s) to Insured: _____

12. Address: _____ City _____ State _____ Zip _____

13. Date of Birth: ___/___/___ Soc. Sec. No. ___ - ___ - _____ Phone #: (___) ___ - _____

14. Contingent Owner: _____ Relationship to Insured: _____

(NOTE: In the event the Policy Owner dies, the Contingent Owner becomes the owner of the policy and assumes all rights of ownership. If no Contingent Owner is specified, the Insured is by default the Contingent Owner.)

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15. **BENEFICIARIES**: Primary: _____ Relationship to Insured: _____

Primary: _____ Relationship to Insured: _____

Contingent: _____ Relationship to Insured: _____

Contingent: _____ Relationship to Insured: _____

(NOTE: In the event the Primary Beneficiary dies, the Contingent Beneficiary becomes the beneficiary of the policy.)

16. **INSURANCE REQUESTED**: Type of Plan:

☐ **Single Premium:** Premium enclosed: $_____

☐ **20-Year Pay:** Initial Premium enclosed: $_____. This is for _____ months.

Select billing preference: ☐ Monthly Auto Pay ☐ Monthly Bill ☐ Bill 3 Months ☐ Bill 6 Months ☐ Bill Annually

NOTE: 1. If Monthly Auto Pay is selected, attach a voided check from the checking account to be drafted.

2. Please specify the day of the month the payment can be drafted.

17. **Amount of Initial Insurance Coverage (calculated from the premium selected to pay): $** _____

18. **"Automatic Premium Loan" provision requested?** ☐ Yes ☐ No

(NOTE: If a premium payment for this policy is overlooked, or not paid for any reason, and if there is a cash value sufficient to pay the premium, a "Yes" selection will authorize the Company to automatically pay the premium from a loan against the cash value. This will help protect the policy from an unintentional lapse. Be advised, however, that no dividends are paid on the amount of cash value used to secure a policy loan).

19. PLEASE GIVE FULL DETAILS TO ANY "YES" ANSWERS: *(Use separate Sheet of Paper if Necessary)*	*NO*	*YES*	*EXPLANATION (If Yes)*
a. Have you used any tobacco products in the last 5 years? If yes, select what form(s): ☐ Cigarettes; ☐ Cigars; ☐ Pipe; ☐ Chewing tobacco; ☐ None	☐	☐	
b. Do you have an application for life or health insurance pending with any other company?	☐	☐	
c. Has any company declined to issue, declined to reinstate or renew, rated, modified, postponed or cancelled any life or health insurance on your life?	☐	☐	
d. Do you intend to fly other than as a passenger on a commercial airline; or have you flown other than on a commercial airline during the last two years?	☐	☐	
e. Do you participate in recreational activities involving mountain or rock climbing, skydiving, skin or scuba diving, or competitive racing of powered vehicles (including motorcycles, automobiles and motor boats)?	☐	☐	
f. Have you lost or gained more than ten pounds in the last twelve months?	☐	☐	
g. Are you currently taking any medication(s)? If so, list name of medication(s), purpose and frequency of use.	☐	☐	
h. To the best of your knowledge, have you ever had, or been told you have had: 1. Epilepsy, nervous or mental condition, paralysis or abnormality of the brain or nervous system?	☐	☐	
2. Heart attack, murmur, stroke, high blood pressure, anemia, chest pains, or any disease or abnormality of the heart, blood or blood vessels?	☐	☐	
3. Asthma, emphysema or any disease or abnormality of the lungs, bronchial tubes, throat or respiratory system?	☐	☐	
4. Ulcer, or any abnormality of the stomach, intestines, rectum, gall bladder or liver?	☐	☐	
5. Urinary sugar or albumin, disease or abnormality of the kidneys, prostate or genital system?	☐	☐	
6. Diabetes, gout, or any disease or abnormality of the thyroid, lymph or other glands?	☐	☐	
7. Arthritis, rheumatic fever, or any disease of the joints, muscles or bones or any disease or abnormality of the eyes, ears, or skin?	☐	☐	
8. Any type of cancer or tumor?	☐	☐	
9. Any physical deformity or defect?	☐	☐	
i. Within the past 10 years, have you been diagnosed as having AIDS or AIDS Related Complex (ARC)?	☐	☐	
j. Have any of your parents, brothers or sisters ever had cancer, diabetes or heart disease?	☐	☐	
k. Other than as stated above, within the last 5 years have you: 1. Consulted, been examined or treated by any physician or practitioner, or been hospitalized for any reason?	☐	☐	
2. Had an X-ray, electrocardiogram or any blood tests or other laboratory tests?	☐	☐	
3. Used cocaine, heroin, LSD, marijuana, PCP, or any other hallucinogenic or narcotic drug?	☐	☐	
4. Been treated or advised to have treatment for alcohol or drugs?	☐	☐	

IMPORTANT: INCOMPLETE ANSWERS CAN CAUSE A DELAY IN PROCESSING YOUR APPLICATION.

I, the Proposed Insured, hereby authorize any medical practitioner or facility, insurance company, consumer reporting agency, employer, friend or neighbor that has any health related records or knowledge of me to give to American Savings Life Insurance Company or its legal representatives and reinsurers, all such information for use in determining my eligibility for insurance or for claims settlement purposes.

I understand that: (1) this Authorization will be valid from the date signed for a period of 2½ years; (2) a photographic copy of this Authorization will be as valid as the original; and (3) I am entitled to receive a copy of this Authorization.

I hereby apply for a life insurance policy in the amount indicated above. I understand that the insurance is not effective until the policy has been delivered and the first premium is paid, while the Insured is living. I have considered my income and insurance needs and feel that this insurance is suitable. I represent that all responses and statements herein are true and complete to the best of my knowledge and belief.

Date	Signature of Proposed Insured if 18 or older	Signature of Policy Owner

Date	Agent's Signature	Agent Number