ALL AMERICAN LIFE Insurance Company
Chicago, Illinois 60631
APPLICATION FOR TERM LIFE INSURANCE

Name of Association: VA Employees Association, Central Office, Inc.

Member's Full Name: _____ Social Security No._____
FIRST MIDDLE LAST

Home Address: _____
NUMBER STREET CITY STATE ZIP CODE +4

Your Age _____ Date of Birth ____/____/____ Sex ____ Male ____ Female Height____ft./____in. Weight _____lbs.

Home Telephone No. (_____)_____ Work Telephone No. (_____)_____

Beneficiary_____ Relationship_____

Spouse Name_____ Date of Birth ____/____/____ Height ____ft./____in. Weight _____lbs.

Child Name _____ Date of Birth ____/____/____

Child Name _____ Date of Birth ____/____/____

(Beneficiary for Spouse and Children shall in all cases be the Applicant.)

Check Life Insurance Plan(s) desired:

a) Life Insurance for member? ☐ $250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐ $_____

b) Life Insurance for spouse? ☐ $250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐ $_____

c) Children coverage? ☐ Yes ☐ No

	Employee		Spouse	
1. During the past two years, were you unable to perform your normal activities for more than 10 consecutive working days due to sickness or accident?	Yes ☐	No ☐	Yes ☐	No ☐
2. During the past five years, have you had Heart Trouble, High Blood Pressure, Albumin or Sugar in your Urine, Liver Disorder, Acquired Immune Deficiency Syndrome (AIDS), Cancer Tumor, Ulcers, Lung Disease, Mental or Nervous Disorder?	Yes ☐	No ☐	Yes ☐	No ☐
3. Have you been confined to a hospital or other institution due to illness in the past six months?	Yes ☐	No ☐	Yes ☐	No ☐
4. Have you or any dependent named above ever had life or health insurance declined, modified, or rated?	Yes ☐	No ☐	Yes ☐	No ☐
5. Are you or any dependent named above now taking medication or receiving medical attention?	Yes ☐	No ☐	Yes ☐	No ☐
6. Have you or any dependent named above been confined in the past 5 years to a hospital or sanitarium or seen a doctor for any reason other than as stated in Question 2?	Yes ☐	No ☐	Yes ☐	No ☐
7. Is this insurance intended to replace or modify any insurance with this or another company	Yes ☐	No ☐	Yes ☐	No ☐

If you answered "Yes" to any part of Questions 1 through 6, give details below. Use a separate sheet of paper, sign and date it, if more space is needed.

Question Number	Name of Proposed Insured	Condition	Date Occurred	Treatment	Names & Addresses of Physicians, Hospitals or Clinics Consulted

AGREEMENT

I understand that the insurance applied for shall become effective on the date specified by the Company only if this application is accepted by the Company and the first premium is paid during the lifetime of the insured. I represent that to the best of my knowledge and belief, all statements and answers recorded on this application are true and complete and are made to obtain the insurance applied for. I acknowledge that the required Medical Information Bureau Notice has been supplied to me. I agree that this application shall become a part of my policy.

I hereby authorize any licenses physician, medical practitioner, hospital, clinic, or any other medical or medically related facility insurance company, the Medical Information Bureau or other organization, institute or person that has records or knowledge of me or any dependent named above to give that information to All American Life Insurance Company. A photographic copy of this agreement shall be as valid as the original. This authorization will be valid for 30 months from the date of this application.

DATE_____ Member's Signature_____

DATE_____ Spouse's Signature (If applying)_____