



Home Office:
 5000 Westown Parkway, Ste. 440
 Des Moines, IA 50266
 Phone 888-221-1234
 Fax 515-221-9947
 www.american-equity.com

Life Insurance Application
American Equity Investment Life Insurance Company
Life Division: 20 Cropwell Drive, Ste. 100
 Pell City, AL 35128
 Phone 877-508-9888
 Fax 205-884-7928

APPLICANT
 Name _____ Sex _____
 Birth date ___/___/___ Soc. Sec. No. _____
 Birth Place _____ Height _____ Weight _____
 Address _____ Phone _____
 City _____ State _____ Zip _____

SPOUSE
 Name _____ Sex _____
 Birth date ___/___/___ Soc. Sec. No. _____
 Birth Place _____ Height _____ Weight _____

CHILDREN
 Date Of Birth Of Oldest Child Under 18 (or age) _____

BENEFICIARY-The applicant is the beneficiary and owner of the spouse policy and any children's rider(s), unless endorsed otherwise.
 Name _____ Relationship: _____
 Name _____ Relationship: _____

Policy form: _____ Premiums: _____ Monthly Bi-Weekly Other _____
 Face Amount: Self \$ _____ Spouse \$ _____ Dependent Children \$ _____
 If available, I request the automatic premium loan provision on the above policy(ies) Yes No

IN THE PAST THREE YEARS HAS ANY PROPOSED INSURED HAD ANY, BEEN DIAGNOSED AS HAVING, OR RECEIVED MEDICAL OR SURGICAL TREATMENT FOR ANY OF THE FOLLOWING?

1. Have any impairments in health or physical condition?* Yes No
2. Had any illness or injuries?* Yes No
3. Cancer, Diabetes, Disease of the Heart, Lungs, Stomach, Kidney, Liver; Brain or any other disease?* Yes No
4. Have or had Alcoholism, Drug addiction, Substance abuse? Yes No
5. Mental or Nervous Disorder? Yes No
6. Currently take Prescription Drugs? Yes No

* AIDS, ARC or HIV must be diagnosed by a member of the medical profession, doctor or a physician.

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, COMPLETE REVERSE SIDE OF THIS FORM.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having available information about diagnosis, treatment and/or prognosis of me or of any member of my family pertaining to any physical or mental condition, including alcoholism and/or use of drugs, and any other non-medical information about me or my family to give the Company or it's reinsurers any and all such information.

5001-OH

NOTE: Make all Checks payable to American Equity Investment Life Insurance Company

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