UNITED AMERICAN INSURANCE COMPANY

A LEGAL RESERVE STOCK COMPANY * Administrative Office: McKinney, Texas 75070

Application for Accidental Death Policy

Benefit Amount
$3,000
($3,000 spouse, $1,000 each child)

○ **Annual Mode of Premium**

Mode of Premium Payment
○ Send Premium Notices
○ Automatic Payment Plan

Day (01-28) of the Month to Draft Bank Account

Proposed Policyholder/Applicant

First Name M.I.

Last Name

Address

City State Zip Code

Age Last Birthday Date of Birth (mm-dd-yyyy) - - Sex ○ Male ○ Female

Home Phone No. - - Work Phone No. - -

E-mail Address of Proposed Policyholder/Applicant

SS # - -

Beneficiary Name Relationship

Spouse
First M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

Child 1
First Name M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

Child 2
First M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

Child 3
First M.I.

Last Name

SS # - - Date of Birth (mm-dd-yyyy) - -

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(Application Continued)

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Child 4 First Name		M.I.	
Last Name			
SS #	- -	Date of Birth (mm-dd-yyyy)	- -
Child 5 First Name		M.I.	
Last Name			
SS #	- -	Date of Birth (mm-dd-yyyy)	- -
Child 6 First Name		M.I.	
Last Name			
SS #	- -	Date of Birth (mm-dd-yyyy)	- -

Is the insurance applied for intended to replace or change any coverage now in force with this or any other company? If "Yes," comply with the application Replacement Regulation or Rule. ○ **Yes** ○ **No** **This policy is not to be used to replace other coverage.**

DECLARATION AND AUTHORIZATION

I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief with respect to any proposed policyholder. I agree that: (1) no policy will be binding upon the Company unless upon its date of issue and delivery each proposed policyholder is alive; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements. I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed policyholder.

I, HEREBY AUTHORIZE the MIB, Inc., any insurance company, hospital, physician or other practitioner having any information available as to my diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment, to disclose such information to United American Insurance Company for the purpose of determining my eligibility for insurance and eligibility for benefits under this policy. I understand that I or an authorized representative may request a copy of this authorization. Information for consumers MIB , Inc. may be obtained on its website at www.mib.com.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Date Application Signed (mm-dd-yyyy) __ - __ - ____

State __

Beatrice O. Salako
Agent's Signature

Signed ________
Proposed Policyholder

Last Name S A L A K Agent No. A 1 5 9 9 0
Print First 5 Letters of Agent's Last Name

Signed ________
Applicant (If other than the Proposed Policyholder)

SEND POLICY TO: ◉ Agent ◉ Policyholder The Policy will be sent to policyholder unless otherwise instructed.

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